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Professional Identity Formation in *Becoming* a GP Trainer – Barriers and Enablers

Doctorate in Education (EdD)

The Open University

Centre for Research in Education and Education Technologies (CREET)

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Abstract

This research concerns itself with the barriers and enablers contributing towards the professional identity formation of the General Practitioner (GP) as a GP trainer. My main research question was ‘What are the barriers and enablers that facilitate the PI formation of a General Practitioner *becoming* a GP trainer?’

I adopted a qualitative case study method within a constructionist, symbolic interactionist paradigm examining the professional identity formation of the GP trainer within one programme area of the Scottish Deanery. Data were collected in the form of (a) semi-structured interviews with 16 GP trainers and (b) regulatory and policy documents. Thematic analysis was applied whilst I maintained a reflexive stance as a previous GP trainer.

My findings indicate GPs become a GP trainer through experiences and events transitioning across three predominant identities: ‘Becoming a Doctor’, ‘Becoming a GP’ and ‘Becoming a GP Trainer.’ Impediment at any of these stages can act as a barrier.

Policy promotes medical students and doctors becoming GPs, thus GP trainers require recruitment and retention. The GP trainer role suggests tendencies for clinicians to be understated in reports of their achievements and abilities. The GP trainer dually enacts and role models that of clinician and teacher; time acts as a significant barrier regarding both. The current Scottish Prospective Educational Supervisor Course, or previous iterations, is a significant enabler. GP trainer associations with Out of Hours services have changed over time. GP trainer / trainee relationships are essential enablers to a continued GP trainer professional identity.

My findings recommend the role of the GP trainer as a teacher needs highlighting. Processes that protect and maximise this role may enhance the positive contributions of being a teacher. Understanding these themes might enhance recruitment and retention of GP trainers. Future research regarding the Scottish Prospective Educational Supervisor Course and GP Out of Hours arrangements are recommended.

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This work would not have been possible without the ongoing love, support, encouragement and understanding of my husband David Ramsay. I wish to dedicate this work to my father Francis McConville who from my early days introduced me to what I might now call an epistemological world, but we know better as our weekly and eternal library visits.

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List of abbreviations

CCT	Certificate of Completion of Training
EURACT	European Academy of Teachers in General Practice / Family Medicine
FRCGP	Fellow of the Royal College of General Practitioners
FRCS	Fellow of the Royal College of Surgeons
FY	Foundation Year
GP	General Practitioner
GMC	General Medical Council
GPST	GP Specialist Trainee
HREC	Human Research Ethics Committee
JCPTGP	Joint Committee on Postgraduate Training for General Practice
JHO	Junior House Officer
LSA	Licence of the Society of Apothecaries
MD	Doctor of Medicine (Medicinae Doctor)
MeSH	Medical Subject Headings
MMC	Modernising Medical Careers
MRCGP	Membership of the Royal College of General Practitioners
NES	NHS Education for Scotland
NHS	National Health Service
OOH	Out of Hours
PI	Professional Identity
PMETB	Postgraduate Medical Education and Training Board
RCGP	Royal College of General Practitioners
SHO	Senior House Officer
SSSI	Society for the Study of Symbolic Interaction
SI	Symbolic Interaction
SPESC	Scottish Prospective Educational Supervisors Course
UK	United Kingdom
WONCA	World Organization of National Colleges Academies and Academic Associations of General Practitioners/Family Physicians

Chapter 1: Introduction

1.1 Chapter outline

This chapter frames the focus and aims of this work combined with the background to the research, including its limits and design. It concludes with a brief overview of the remaining chapters of this thesis.

1.2 Research focus and aim

The focus of this research concerns itself with the barriers and enablers towards the professional identity (PI) formation of the general practitioner (GP) as a teacher (trainer). It aims to concentrate on teacher development and professional learning by examining that which impedes or empowers the PI construction that occurs when a GP chooses to become a GP trainer.

This research stems from my personal and professional interests regarding both professionalism and identity formation. As a researcher, I wish to contribute something unique to this arena of healthcare literature and GP academic research in particular. The latter area being one which Chew-Graham (2019) suggests currently lacks sophistication and generalisability in terms of research conduct and design. I hope to address this in one small part.

Through my own experiences, the GP who becomes a trainer can be imparted with new educational knowledge, skills and attitudes. Questioning the elements that may constitute *being* this persona is what I wish to examine. It is the feelings and processes, or that which affects them, in *becoming* a professional that is the specific focus of my research as this is a gap, as I will subsequently outline, which has yet to be addressed. I have drawn on my personal journey and encounters of the route travelled in becoming a GP to being a GP trainer. Thus, in considering these possible changes in professional practice, I reflect, learn and take into account their influences throughout my research and on my PI as a doctoral scholar.

As a personal tutor to medical students and as a GP teacher and trainer, I have encountered students engaged with a broad spectrum of challenges associated with professionalism and their emergent professional identities. This study is explicitly based on the premise to

understand what the barriers and enablers for a GP are, as they *become* a GP trainer. What is it that these GPs are undertaking within their personal and professional lives that helps them identify themselves as the emergent teacher? What are their experiences, thoughts, feelings or strategies that they encounter that may address or amplify these challenges, which they face? Responses and findings arising from this research may help identify their needs and thereby inform future trainer development, educators or the wider professional bodies of interventions and teaching methods needed to address such gaps.

Within medicine, and medical education specifically, the concept of PI and its formation is an area that has gained attention in recent years (Cruess et al., 2014). In chapter two, my literature review, I critique in detail the unfolding evidence that has emerged that seeks to outline and imbue that which might be viewed as a definition of PI. However, as I will continue to argue within my thesis, I draw on the definition of PI as defined by Cruess et al. (2014) who suggest that,

‘...a physician’s identity is a representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized, resulting in an individual thinking, acting, and feeling like a physician...’ (Cruess et al., 2014, p. 1447)

Currently, there are several key influencing factors which are set to drive forward the engagement of the availability of GPs and, more specifically, GP trainers for the future. The Royal College of GPs (RCGP) had set out a blueprint ‘...to reverse the impacts of the increasing problems of workload and recruitment on the ability of GPs to deliver excellent patient care...’ (RCGP, 2015a, p. 2). One element of their argument is to expand the number of GPs, balanced by their concerns that 20% of the current workforce may retire in the next 5 years. It therefore makes sense, to establish what may be needed to encourage new, as well as retain existing GP trainers, in order to promote the continuation of the GP profession. More recently, locally, RCGP Scotland (2019) have also provided a reinforcing message of the need to enhance the workforce target by 2024/25 that is based on whole-time equivalent figures and not just a headcount, thus effectively again seeking to call for a growth in GP numbers. A snapshot taken from the medical profession’s governing body, the General Medical Council (GMC), indicates that of the 289,115 registered doctors in the UK only 25%

of these (72,318) are GPs, with GP trainers a smaller subset, 8035 (i.e., approximately 11% of the GP population) (GMC, 2019). This indicates a need to ensure a match between creating new GPs whilst having sufficient trainers to implement such processes.

The expansion of the profession is not a new discourse. Indeed, previous authors such as Pitts et al. (2005) have provided discussion ten years before this at a different time of change within the National Health Service (NHS). In their time, they highlight the importance of growing the scope of primary care-based training to address the then crisis of recruitment and retention of GPs. It would appear little has changed over time (Doctors.net.uk., 2019) and so the dialogue continues, albeit the promise of new changes emerge on the horizon with the introduction of new GP contractual changes in 2018 (Scottish Government, 2017).

Changes or developments in primary care have already been previously recognised by Beaulieu et al. (2008) in taking account of far-reaching models of professional practice that, in ensuring optimum use of available expertise, suggest that professional roles must change. Indeed, previous authors Pitts et al. (2005) as above, have made suggestions within a differing era that might lead to an increase in scope for primary care-based training to contain the then requirements of the NHS. This included the need for extra primary care-based training appointments to realise the ‘Modernising Medical Careers’ (MMC) initiatives (Department of Health, 2003), which provided more general practice experience.

Thus, my study aims to provide a description that may assist in the explanation of barriers and enablers towards PI formation within healthcare professionalism, more specifically, GP trainers. I would hope that new insights provided by my research may provide additional evidence and suggestions that will allow curriculum developers, educational bodies and monitoring organisations or committees to redress, support or disseminate information to the relevant interested parties.

I have reason to believe this current study is unique in terms of its approach. At the time of writing, work has retained focus on predominantly positivist research designs in order to capture methods of assessing professionalism within medical education. Lynch et al. (2004) describe how at least 88 professionalism assessment types have been used in medical education since 1982. These variations in scales and assessments position themselves predominantly within a psychometric, self-reported, data collection spectrum under

summative assessment frameworks. These authors proposed the need for research to answer questions in which the features of educational locations that encumber or endorse teaching and assessment of professionalism occur, as well as tailoring assessments for longitudinal use. This thesis aims to address some of this recommendation in part by prescribing an alternative, qualitative method that instead aspires to capture the barriers and enablers of GPs and their experiences as they assume the professional identity of the GP trainer.

Additionally, Passi et al. (2010) in their systematic review suggest that in the multifaceted complexity which is professionalism, there still exists no evidence-based strategies for teaching and assessing professionalism balanced with the evolving demands of individuals, society and political expectations on the professions. This thesis, therefore, aims to identify themes that currently predominate within the changing PI of one area of healthcare professionals. In doing so, this may inform curriculum designers and educationalists of points where such strategies may be best placed.

Although the literature (Berger et al., 2020; Passi et al., 2010) retains a focus on a quantitative approach, there have been invaluable contributions from key authors who position themselves within a qualitative dimension. Rees (2005) suggests that while research has addressed the components of professionalism and their assessment, little work has explored how professionalism i.e., how PI develops. Thus, is the suggestion, we need to construct a more complete developmental theory of such formations. Subsequent work by the same author (Gordon et al., 2020; Monrouxe et al., 2011; Rees and Knight, 2007) suggests evidence of the importance of doctors' identity transitions, the need to capitalise on the emerging literature on reflective portfolios and the importance of experiences of professionalism dilemmas.

Additionally, the notion of professional identity and identity formation is an area that is new and emerging from within the field of medical education (Cruess et al., 2014). It is a field that draws its theory from the social sciences (Burke and Stets, 2009) originating from a composite of work by Mead (1962) utilising symbolic interaction (SI) combined with ideas which stem from perceptual control theory by Power (1973). This exploration of identity and its formation is both a personal journey of professional self-discovery as well as that of a researcher, based on the hope that it allows additional contributions and the provision of simplified explanations, of these processes, to a new audience of readers, combined with my

personal enlightenment. The importance in terms of context and background is further elaborated on below.

1.3 Background and significance of the research

Irby et al. (2010) in their calls for reform for medical education argue that the Flexner model, serving for much of the twentieth century, must be reconstructed to stimulate excellence in medical education for the twenty-first century. As the landscape of medical education continues to change within the UK (Brice and Corrigan, 2010), the environment for the medical student and medical educator exudes a fast pace. As a component of their key findings and recommendations, Irby et al. (2010) suggest amongst four critical themes that one should concentrate on the advancing formation of professional identity.

Ginsburg et al. (2010) suggest that educators within medicine have differed in their use of applying ‘competency outcomes’ regarding use as an educational framework to organise and influence learning versus endeavouring to convert them directly into evaluation tools. Hodges (2019, 2006) discusses this same issue and proposes that including identity in parallel with competencies allows for an adjustment of attitudes to medical education away from a sole focus on ‘doing the work of a physician’ towards a larger arena that also includes ‘being a physician.’

Likewise, Boudreau et al. (2014) argue that competency-based approaches lack explanations that withstand identity transformations. They suggest that the urge to produce a standardised edition of the clinician as a professional can dampen individualism and adversely affect identity formation. They go on to suggest that medical education would benefit from a longitudinal inquiry into how medical identities are developed, portrayed, and sustained.

Such enactment is also commented by Jarvis-Selinger et al. (2012) who propose that identity formation theorists express and bring into question matters presently underexplored in medical education. One example, in examining GMC competencies, identity theorists would question the basis on which medical educators have regarded the concepts of ‘roles’ and ‘competencies’ as interchangeable (GMC, 2018a). They contend that roles and competencies are not identical but, instead, that roles are socially constructed (not to be confused with

identities), and competencies are a behavioural demonstration. Therefore, instead of supposing that it is conceivable to specify a collection of essential physician behaviors, it might, as an alternative, be sensible to consider how institutional roles, behavioural competencies, and evolving identities work together in the course of becoming a physician, or in this setting the GP trainer.

Thus, it might be viewed as essential to understand how and when each trainer role might be, at any point, either compatible or incompatible with the fundamental PI that an individual is pursuing. In either case of compatibility, Jarvis-Selinger et al. (2012) suggest it can be a crucial time for delivering feedback about the consequences for their understanding of their progress toward their goal of becoming a professional as a supplement to their capability to do the things they are supposed to be able to do.

Currently, the GMC (2018b) requires that medical students are assessed and monitored utilising a number of domains and areas. These address issues associated with the concepts of professional values and behaviour, skills and knowledge. Assessment in medicine is itself a vast expanse of debates and discussion. Hafferty (2006b) suggests that the debates over meaning and measures of professionalism have been vigorous and visible. Moreover, he suggests that there is a genuine possibility that educational establishments will anoint a particular measure or methodology as ‘the one’ and thus pronounce that the ‘professionalism problem’ has been unraveled. He then proceeds further to suggest that,

‘...the social and interactive nature of professionalism demands that the medical education community (which includes faculty, students, administrators, and practising clinicians) has a fiduciary responsibility to keep the professionalism debate ever alive and ever vibrant...’ (Hafferty, 2006b, p. 282)

My thesis builds on the work by Cruess et al. (2014) by seeking to continue this debate while adding a new layer associated with PI formation and its theories. Also specific to the concept of professionalism Martimianakis et al. (2009) suggests that there have been two prevailing styles in the literature. One approach is abstract and considers professionalism as a mirror of the social liaisons of ‘a profession’, while the other concentrates on the operationalisation of professionalism as something to be assessed. Currently, the latter approach is one which we see as more dominant within health systems curricula; Wilkinson et al. (2009) provide an

example of this with a robust systematic analysis which even then highlights the complexity of the landscape. At that time, they suggest there were five clusters of professionalism being formed with nine groups of assessment tools for professionalism in use. Given the GMC's requirement of medical students, it is unsurprising that they, therefore, ask the medical institute to have in place a system that assesses, monitors and addresses these issues of professionalism. This focus on professionalism, as previously highlighted by Papadakis et al. (2004) is not only based on evidence of the time but also influenced by the changing demands of the public and its perceptions.

In contrast however, public perceptions and the social contract that exists between health care professionals remain under constant scrutiny and critique, especially in the event of prominent cases which reach the attention of the media and headline news (Dyer, 2018; Martin and Dixon-Woods, 2014; Horton, 2001). The changes in this social contract that occur, require a constant reassessment of values and beliefs and within this complex interaction sits the emergence of the professional and their identity. Recent examples such as the Mid Staffordshire enquiry (Martin and Dixon-Woods, 2014) or the current Coronavirus pandemic crisis (Godlee, 2020) exemplify how relationships are a moving landscape within professions, public and the law. Indeed Hafferty (2006a) suggests that in the search for the definition and meaning of professionalism one needs to be aware that it is a dynamic entity. He indicates medicine's social contract with society is under constant renegotiation, something infrequently addressed in most treatments of professionalism. This thesis, therefore, aims to shed new light on this debate by focusing on this complex intersection of being both a professional and the identity formation of the developing educator.

Weight can be added to this argument with commentary provided by key authors in professionalism such as Cruess (2006) who suggest that attempts to establish longitudinal programmes of instructions also require the development of more effective means of providing a supportive environment that creates 'scaffolding' towards such behaviours (Wood et al., 1976). In understanding these processes, it is therefore important to address core themes which are connected with this. Approaching from this position, one needs to be aware of the current context and the history with regards to the developments of PI in medical education. In particular, one also needs to be mindful of the specific literature that relates to PI and its development within the world of education as a whole.

Identity theorists (Burke and Stets, 2009) and medical educators alike (Cruess, 2006) comment that PI emerges from a long-term amalgamation of experience and reflection thereon. Given that this is the case, one would therefore expect that work is needed that addresses these issues over an extended period, in order to gain new insights. Thus, while examples linked with PI can be associated with apprenticeship (Boudreau et al., 2014), professionalism dilemmas (Monrouxe et al., 2014; Rees et al., 2014a) or bedside interactions (Rees et al., 2013), none currently examine the emergent PI of the GP trainer or its associated barriers and enablers. This thesis redresses this space.

In addressing this research need, I believe that one needs to understand the history of identity formation broadly including its theoretical frameworks and connections with educational pedagogy as well as the current context of PI within the medical education literature. If one believes, as Crossley and Vivekananda-Schmidt (2009) suggest, that a postponed PI is an obstacle to a successful transition from student to professional, then I hope that my research may provide insights into barriers or enablers that may occur in the developing GP trainer's career. PI as situated in a sociological psychology context (Burke and Stets, 2009), examining the GP trainer's career, thus adds new research to current gaps. If as Burford (2012, p.146) advocates that, '...social identity is also linked to performance later in careers...' then additional insights from my research may provide benefits to the medical education community and parties of interest. Eva (2013) reinforces this approach by declaring that how we speak to health professional education via the discipline of the social sciences can notify the field to new or less studied positions of educational practice within the professions.

Hafferty (1998) reminds us it is important that medical educators be ready and able to step back and assess just what meanings are being created by and within the very organisations they have developed. In doing so, this thesis thereby aims to provide new insights and directions into the support and identity formation of the GP trainer for the future. The questions that have been constructed to address this are outlined below.

1.4 Research question

Staying close to the title of my thesis, this research addresses the primary research question below, namely:

What are the barriers and enablers that facilitate the professional identity formation of a General Practitioner *becoming* a GP trainer?

This question has been constructed from my pre-existing experiences as a GP trainer to date. Whilst mindful that the informing literature, as critically analysed further in Chapter 2 will show, can cause a research question to evolve over time. Ultimately, this research has aligned with the above question throughout the research design, findings, discussion and conclusions that will be presented.

1.5 Structure of the thesis

This report has been divided into six chapters:

- In chapter two, I have critically reviewed the core literature concerning professional identity formation allowing for the nature of the research question. I search for key insights accounting specifically for healthcare professionals and GPs within the areas of professionalism and identity formation theories. The influences of the current political climate and overarching policies are scrutinised, as are the overlapping fields of the wider arena of education.
- In chapter three, the research methodology and methods are outlined. Its position of a qualitative design centred on a case study approach combined with the underpinning rationale is described. It covers in detail the methods used, i.e., GP trainer participant selection, semi-structured-interviews, document gathering, ethical considerations, data collection and analysis.
- In chapter four, the findings are described under three main themes of ‘Becoming a Doctor’, ‘Becoming a GP’ and ‘Becoming a GP Trainer’ and their subsequent sub-themes.
- Chapter five discusses these themes along with critical linkage to the current and emergent literature. The themes indicate that impediment at any of these stages can act as a barrier in becoming a GP trainer. They illustrate how the role of the GP trainer suggests a tendency for the trainer to be understated in reports of their achievements and abilities and how the GP trainer dually enacts and role models that of clinician and teacher. Time, I argue, acts as a significant barrier regarding both.
- Chapter six provides conclusions to this study encompassing future recommendations for policy, practice and research. I propose that the role of the GP trainer as a teacher needs to be highlighted. Processes that protect and maximise this role may enhance the positive contributions of the GP trainer being a teacher and an educator. The limitations of the quality assurance processes are then considered to ensure that a rigorous research approach has been applied.
- References, appendices deemed important to my text such as my coding framework and a glossary, have been included to enhance the argument set out by this work.

Chapter 2: Literature Review

2.1 Chapter outline

This chapter describes the approach taken to review and remain abreast of the identified literature in this research. It commences with a discussion on the centrality of the major underpinning theories and philosophical stance informing this research. It then proceeds to outline the influencing evidence utilising a selected historical critique and review over four main research areas.

2.2 Literature approach

At the outset of this research a critique of the literature published 1 Jan 2000 to 30 June 2017 was undertaken to identify writings centred on the areas: GP trainers, teachers and professional identity formation. Searches were employed across multiple databases thought likely to elicit relevant evidence:

- British Education Index
- Conference Proceedings Citations Index – Both Science and Social Science and Humanities
- Educational Research Abstracts
- Educational Resources Information Centre
- PubMed
- Scopus

Within the cross-search process, consideration was given to performing explorations specific to GP trainer and professional identity using medical subject headings (MeSH) terms in title/abstracts. At the time of writing, no MeSH terms exist that incorporate both the terms 'General Practice' and 'Family Practice'. No such MeSH terms exist for trainer (teacher) nor professional identity additionally. Consideration has been given to the *grey literature* (GreyNet International, 2017) as appropriate considering that the subject matter of both GP teaching and professional identity formation are areas rich in the field of academic text.

Appendix 1 (p. 198) illustrates the inclusion and exclusion criteria that were applied to each area of the literature searches. Throughout the research process, an overview of current literary developments in these areas has been maintained. This has been addressed by weekly

update searches constructed within PubCrawler (2017) and Zetoc (2017) along with citation alerts for articles determined as being of key influence. As expected, literature searches failed to establish clear GP training policy documents given the location of such materials. Direct liaison was therefore made with the RCGP library and archive department to identify informing policies and documents.

Appendix 2 (p. 200) provides an example of how I have summarised the key findings from the literature searches undertaken above. Each area contains:

- details of the literature search
- key authors in the research topic
- the reviewed articles listed by publication date including abstracts and notes
- articles which have similarities have been cross-referenced

The critiques of the literature aim to examine the writings to gain a deeper understanding of the areas of ‘GP Trainer’ and ‘Professional Identity’. In particular I have constructed this literature review process in order to ascertain that the research question that I have sought to address, does indeed, pose a query that exists as a gap in current evidence. In doing so I have mapped out the current literature in a way that outlines clearly, key areas of importance to my research. Boote and Beile (2005) highlight the centrality of the literature review in the doctoral process; in doing so, I have, therefore been mindful of their suggested standards and criteria. In my approach to the literature selected, I have chosen to bear the suggestions from Creswell (2002) in mind, given that these provide clear and concise steps in identifying the most relevant writings.

The four main research areas that have been identified, mapped and reviewed are:

1. GP trainer policy and practice influences with a specific focus drawn from the Royal College of General Practitioners
2. Professional identity concerning the GP trainer/educator specifically
3. Professional identity formation and medicine more broadly
4. Professional identity formation and teaching

What follows below is a historical summary to date of the critical synthesis of these topic areas. Throughout this analysis, the primary focus that was being kept in mind was evidence that assists in addressing the primary research question outlined above. However, prior to this, I outline selected elements of major theories and philosophical assumptions with respect to identity formation.

2.3 Identity theories

Due to the literature's expanse with respect to identity and associated theories, I have limited my discussion to key works published with an aim to synthesise assumptions that are relevant to addressing the research question posed by my study. It can be helpful to consider common identity concepts in existence associated with underlying 'grand theories' as described by Crotty (1998) whose writing seeks to provide scaffolding to an approach to unpick the constructions of a social research process such as mine. I will draw, in particular, on the roots from within the social psychological literature since this is where this specific research deems to be grounded.

Schwartz et al. (2011) introduce their voluminous *Handbook of Identity Theory and Research* by highlighting that identity is a powerful construct that is increasing dramatically concerning published literature. Indeed, they suggest that 'knowing' the identity literature can only really involve understanding one small corner of that expanse. Their work highlights how identity theories can range from constructs aligned with the developmental psychologist entrenched within a neo-Eriksonian world (Kroger, 2018; Schwartz, 2001), e.g., the spectra of identity synthesis to identity confusions. However, Schwartz et al. (2011) also then compare the perspectives of the sociologist or social psychologist who view identity as situated from within the world of our relational interactions and the meanings we might give to them (Society for the Study of Symbolic Interaction, 2019).

In developing a definition of identity, Schwartz et al. (2011) proceed to suggest that this fundamentally involves people's implicit or explicit responses to the question 'Who are you?' They invoke the notion that in addressing this, the 'you' can be singular or plural thus identity can refer to self-definition of individuals (I am a mother, I am a GP), as well as pairs of individuals, small face-to-face groups and larger social categories (we are parents, we are GP trainers). Secondly, however, they also indicate that this question might be posed reflexively.

Thus 'Who am I?' or within a group 'Who are we?' In other words, there is the suggestion that identity evokes elements of not only 'who you think you are' (individually or collectively) but also 'who you act as being' within intergroup or interpersonal relationships, and especially in terms of PI, a view we see articulated by others (Skinner et al., 2016; Wickham, 2016). This might be, perhaps, of significance with respect to PI and its formation as my critique of the literature will continue to show.

Thus, Schwartz et al. (2011) set the scene through their in-depth accounts of four main aspects of identity that provide the basis for an integrated operational definition. In doing so, they suggest that identity can be best viewed through the divisions of the individual, relational, collective and materialistic approaches. At an individual level, identity, therefore, can consist of characteristics such as beliefs and ascribed commitments (Kroger and Marcia, 2011) or components of self-esteem (Cantillon et al., 2019) as examples. Relationally involves roles and positions with respect to others, e.g., co-worker (Touati et al., 2019) or parent (Long et al., 2018). Collectively, this might involve elements of membership within certain social groups and categories (Gordon et al., 2020), while materially one may be defined by identification with treasured physical possessions or a sense of geographical space (Somporn et al., 2018). Each and all of these areas have within them a multitude of underpinning theories and frameworks. However, in addressing my focus on GP trainers, what follows are areas that are of more salient detail and relevance.

Personal and developmental perspectives of identity

Kroger and Marcia (2011) suggest that much of identity theory is based upon 'The Identity Statuses'. The origins of this specific theory are drawn from psychosocial development, more specifically psychoanalytical theory and the writings of Erik Erikson (1950). Erikson, in spelling out the eight stages of ego growth, therefore draws on the pedigrees of these descriptors as suggested by Freud (1946). Emergent from these works are the concepts that as an identity is formed, the individual must undergo an element of *exploration* (originally called *crisis* in early Eriksonian writings) and ultimately *commitment* (or not) to a variety of roles or life plans. Kroger and Marcia (2011) utilised a scoring inventory, suggesting that four possible statuses might be seen to have interest within their form of identity research, namely: identity achievement (commitment to the role with a high-intensity exploration of it),

foreclosure (commitment to the role by taking on commitments from others with little or no exploration of the role), moratoriums (engaged in exploration but struggling to commit) and identity diffusions (whereby there was low, or absent, levels of exploration and commitment).

However, one must bear in mind that most of this research positions itself within a positivist approach (Bunniss and Kelly, 2010) often reliant on measures of construct validity (Colliver et al., 2012) and their use of meta-analyses. Even within more recent standards of where this approach might take us, while Schachter (2018) reflectively acknowledges her recommendations are based on a personal review only, I am left with a sense of the predominant favour towards the world of the psychodynamic psychologist. Thus, as I will continue to show, while I recognise these as possible constructs that might emerge within my research, they cannot be measured in the same way as this body of literature purports, nor align with my underpinning methodological approach.

In considering the view of identity through the lens of a social-cognitive perspective via identity construction (Berzonsky, 2011), one might initially be impressed that such a view aligns better with my body of research. Berzonsky (2011) outlines his model based on constructivist epistemological assumptions postulating that people play a role in constructing both a sense of who they think they are and the 'reality' within which they exist. Here, he suggests that based on the four identity statuses described above, individuals may have three differing styles in their approach to an identity crisis. In describing these styles (the informational, diffuse-avoidant and normative identity-processing orientations) he then, unfortunately, draws back to explore these using operationalised identity style inventories. Thereafter, the body of the literature appears to approach this framework under a clearly aligned, positivist approach whereby the discourses of convergent validity, dual-processing and cognitive processing models remain strong (Berzonsky, 2011). Culminating in hierarchical regression analysis, I would derive that this body of theory, while important to identity as a whole, again would not align with my intended model of research.

Suggestive of better alignment, the theoretical underpinnings of narrative identity as portrayed by McAdams (2011) describe the internalised and ever-evolving story of self that provides a person's life with some semblance of purpose, unity and meaning. Complete with context, settings, plots, characters and themes this narrated identity can be formed from recollections of the person's past, as well as thoughts on an imagined future, to recount a

subjective story of one's development. McAdams (2011) suggests that this concept fully emerged via developmental psychologists in 1985. Now spanning 30 years, the concept has grown and developed in multiple directions to become a multi-level theory of personality.

McAdams (2011) proceeds to suggest that the body of work in this area rests within: relationships between narrative themes and personality variables, life narrative predictors of psychological well-being and health, narrative variations in how people make sense of negative life events and suffering, interpersonal and social effects of life storytelling, narrative in therapy and the cultural sharing of narrative identity. It is only in the latter that one might see reflections of elements that have the potential to emerge within my study. Indeed, occasional stories specific to the medical literature (Berger and Mohr, 2003; Kay, 2017) have been noted to have possible relevance to where my study is positioned. Nevertheless, as I will continue to argue, while mindful of the importance of narrative, theoretical underpinnings, the philosophical basis of my research rests in a differing place; certainly, one not within the world of the developmental psychologist amongst others. Thus, I turn instead to the world as argued from the literature within a socially contextual perspective.

Social and contextual perspectives of identity

Chen et al. (2011) introduce this area of identity literature by describing the emergent theory and evidence of the 'relational self' from personality and social psychology writings. They offer an integrative conceptualisation of the relational self, drawing heavily from social cognition work on transference, relational schemas and attachment theory. They suggest that this concept is viewed as the relational self, being one that reflects who a person is *in relation to* their significant others. They base this on four key assumptions. Firstly, the relational self is comprised of knowledge about the self when relating to others (and linked with memory). Secondly, that this exists at multiple levels of specificity, e.g., relationship-specific, global or general. Thirdly that the relational self can be activated from memory and lastly that it is composed of self-conceptions as well as a constellation of other self-aspects, e.g. goals or self-regulatory strategies. They integrate this framework with that of Sigmund Freud's (1958) concept of transference (namely the phenomenon whereby aspects of past relationships resurface in encounters with new others), arguing that the content of relational

selves also includes socially shared facets, such as the role enacted with significant others, e.g., parent.

The final facets of the relational self that Chen et al. (2011) invoke also contains the use of both relational schemas who they exemplify via Baldwin (1992), and attachment theory as ascribed by Bowlby (1969) and Ainsworth (1978). While Chen et al. (2011) proceed at length to argue and evidence the underpinnings of these representations within their work and the value with respect to identity overall, the direction of the work invokes a strong social cognitive theme that aligns primarily more with that seen from the locus of the psychologist (Tagawa, 2019) than from within the socio-contextual context that I seek to position. Although they signpost to future areas of interest using their theory, such as how transference affects people's sense of belonging within a group or the use as a tool for reducing negative biases within group identity, their work speaks the language of the social psychologist rather than the educationalist from which I believe this research resides. Dwelling, therefore, not on the relational self, I move instead to highlight the importance within the literature of discourse and identity construction.

Bamberg et al. (2011) introduce their work by suggesting that the construction of identity from a discursive point of view requires the dual lenses of *discourse* and *construction*. Intimating the roots to this lie within psychology and linguistics, they draw on a constructionist framework indicative that phenomena (internal or external) have their reality in an intersubjectively reached agreement that is culturally and historically negotiated. In this frame, they suggest a shift away from what identity *is* and focus instead on the processes in which identity is *done or made*, or as my title states, '*becomes*,' via the activities constructed through discourse. They suggest that the three most pressing areas in which to explore this should focus on: agency and control, difference and sameness and constancy and change.

Drawing parallels with the roots of narrative analysis, they move to a world where exists the concepts of capital-D and small-d discourses that were outlined by Gee (1999); conversations that still ensue today (Links et al., 2019). Bamberg et al. (2011) suggest that D-discourses view a person as being constructed in and through discourse, while in d-discourse the person, through agency, constructs who they are by use of dialogue; they highlight that these differ in terms of how they are steeped via agency and control. Within these works, I make no suggestions to unpick the words that they cite (Bamberg et al., 2011, p.181) with respect to

Foucault, Habermas or Lyotard as master theoreticians who posit what the necessities of discourse are. Indeed, as a researcher attempting to articulate, let alone synthesise, participant's differences concerning syntax, lexicon, pronunciations or speaking styles, this moves far beyond both my skillset, perhaps also that of my future target audience with respect to findings and conclusions of this research. Such that, while I recognise and accept the importance of the lens of discursive practices on that which are identity theories, for the sake of brevity and ease of understanding, I choose to move in a direction that enhances the literature from a differing position.

One such position are the concepts that belong to identities as perceived by groups through the stance of a social identity perspective. Spears (2011) narrates this as being the dominant approach to group identity within social psychology. In doing so, he suggests that this is primarily concerned with 'social identity theory' and its close relative 'self-categorisation theory.' Originating from the work of Tajfel (1978), social identity or group identity might be defined as having cognitive and evaluative terms, being that part of the self-concept corresponding to knowledge of group membership, together with the value and emotional significance of that membership. In essence, it describes processes of social categorisation into groups, followed by a social comparison between these groups, by people who define or identify themselves as being part of them. More specifically, there is a presumed positive sense of belonging derived from such group membership, possibly from the loosely defined, (e.g., a fan at a sports event), to the significant, (e.g., such as a state nation in the process of war or exiting from a union).

Spears (2011) proceeds to highlight that there is importance in the work of Tajfel (1978) with respect to not only being a group member but that from which the group comparison must happen. Discounting early theories of the minimal group paradigm, Tajfel (1978) highlighted that just being assigned to, or part of a group is not enough. It is the motivated quest for positive group distinctiveness that may be key. This is a salient component that may well be important in driving answers to the research question posed in my thesis. I have certainly noted this theory situated within other research containing medical students that might draw parallels to my GP trainer research question e.g., Weaver et al. (2011) in their research concerning how medical students must develop both a PI but also an inclusive social attitude for effective medical practice in the future. However, while this is not the theory upon which my study wholly rests, bearing this concept in mind may be of use. Drawing on my

experiences as an insider researcher (Humphrey, 2013; Hellowell, 2006), I postulate that the products of *being a GP trainer* rest not upon membership to a specific group of GP trainers / educators, but instead to something that is more constructed from within one's internal self; albeit acknowledging that GP trainer group membership is essentially a by-product of this course of travel.

This course of travel is essentially reinforced by Spears (2011) who summaries that while social theory is more than just a theory about discrimination, it is engaged primarily with ideas of social change, equality and liberation. This is an area perhaps too broad-based with respect to providing meaning to GP trainer identity. One recent, seemingly robust example of such theoretical applications can be seen more clearly used by Harlow and Benbrook (2019) in the context of the '#BlackLivesMatter movement.' Indeed, the second element of group identity, that of work with regard to self-categorisation theory (Turner, 1982), i.e., the view of the self as posed by *intragroup* as well as *intergroup* processes also, may be seen to be positioned within the same light. While being of clear importance within identity theory overall, I remain unconvinced that findings from my research will align with concepts such as social stereotyping or depersonalisation; discourses of self-categorisation which I think unlikely to emerge from my personal experiences, or perhaps those of my participants, from being within a GP trainer community. Thus, while acknowledging the importance of social identity theory towards the literature as a whole, I instead turn to outline the underpinning philosophy upon which my research rests and is justified latterly within the 'Methodology and methods'.

The Symbolic Interactionist perspective and identity theory

Considering the future implications of my research, finally, therefore, I wish to highlight the position that this study does deem to situate itself within theoretically. I have explored the underlying roots of identity theories and their relationship with frameworks that position themselves from a personal and developmental perspective to a social and contextual outlook. Below, I elaborate on the social and contextual standpoint as outlined by the ontological premise that is symbolic interactionism (SI), more specifically, structural SI. In doing so, I draw on identity theories as postulated by academics in this area and will demonstrate again latterly in Chapter 3 how this will be applied within the context of my research. Thus, it is worth highlighting at this point that as such, I ascribe to the current and most dominant

definition of SI as outlined by the Society for the Study of Symbolic Interaction (SSSI) (2019) to bring alignment with my research and recent evidence. In doing so, they suggest that this perspective is stated such that SI is about how, ‘...people act toward things based on the meaning those things have for them, and these meanings are derived from social interaction and modified through interpretation...’ (Homepage of the SSSI, 2019).

Multiple authors (Serpe and Stryker, 2011; Burke and Stets, 2009; Charon, 2007) all acknowledge that one of the cornerstones of the symbolic interactionist perspective originates from the works of 18th-century Scottish moral philosophers such as Smith (1759) and Ferguson (1792). Serpe and Stryker (2011) remind us that the concept of SI emerged latterly via Herbert Blumer, who was actually describing the ideas of Mead (1962). Thus, SI could be said to build on the premise that the state of human nature is a social one. That society is created via social relationships, communication and interaction based on sociability, with society being a mirror in which people see themselves. Over time, evolving adaptations have added to this school of thought. Serpe and Stryker (2011) highlight William James’ contribution with respect to self-esteem and consciousness, the ‘viewed self’ being multifaceted and a product of heterogeneous society. Important also is Dewey’s (1930) view of human evolution as adaptations to environmental conditions, along with Cooley’s (1902) belief that self is defined and developed in interaction with others - a product of a looking glass process involving managing our portrayed impressions and associated feelings.

If one looks for a contrasting opinion to that of the descriptors of SI via Mead (1962), then counter-poised are the arguments that originated from Kuhn (1964). If Mead was said to argue that from within SI could be achieved ‘after the fact’ understandings but not hope for theory-based explanations of social change, then Kuhn contended that it was possible to aspire to theory-based generalisations and their rigorous empirical testing thereof. Therefore, while both take the ontological disposition that begins with society as a web of communication or interaction that creates the person while simultaneously, the interaction of persons creates society. They digress when concerning other issues, thus setting the stage for two opposing schools of thought within the SI field, i.e., traditional vs structural SI.

Serpe and Stryker (2011, p. 230) helpfully summarise the critical differences between these two components of SI, which I have adapted for the sake of brevity in Table 1 below (permissions granted). In doing so, I would, therefore, highlight the fact that I view my

research positioned such that it aligns more closely with the work of the structural SI. Thus, ultimately, I seek to not only describe and understand the events occurring within the context of this work but also provide a suggested framework with respect to explanations and possibly even predictions of future GP trainer needs.

Table 1: Comparisons of traditional and structural symbolic interactionism adapted from Serpe and Stryker (2011, p. 230)

Traditional SI	Structural SI
Neglects the relatively ‘fixed’ nature of social structure	Examines the role of social structure in social life
Social structure is thus viewed as in a ‘flux’ (a continuous revised process of being created and recreated through interpretations, definitions and actions)	Society is relatively stable and durable as reflected in patterned behaviour within and between individuals
There is no overarching organisation or structure from the view of the individual	Social structures generally have boundaries
Only the perspectives of participants in social interaction are relevant. Consequently, the voices of observers have to be eliminated.	On how actors and social structure relate to one another but these alone are insufficient as explanations
Describe and understand events only	Describe and understand events leading to explanations and predictions
Self emerges from society but becomes free of structural constraints overtime	Self is a conduit through which prior social organisation and structure reproduces themselves
Examine for sensitising concepts but deny that <i>a priori</i> theory can exist as there exists no stable reference point	Will utilise <i>a priori</i> theory in order to develop and test predictive explanations
Requires commitment to qualitative methods	Both qualitative and quantitative methods are acceptable

In considering a possible framework of findings that may emerge from my research, I am mindful that Serpe and Stryker (2011) perhaps reinforce this in their suggestions that structural SI must have an adequate social psychological scaffold, for both the symbolic, as well as the structural, such that they are viewed as mutually operational. Thus, role concepts provide a basis for social structure lending themselves to the ‘building up’ of units of social organisation, something reinforced by the writings of others who seek to describe what it is that makes SI unique from other predominant theories (Leeds-Hurwitz, 2006). In doing so,

the authors thus suggest that there exist internalised expectations attached to particular networks of social relationships and associated reflective compatible or conflicting expectations. One can see a recent such example of an approach via Everitt and Tefft (2019), who combine teacher career interviews (n=27) together with ethnographic observations of teacher education (n=49) in order to make meanings from these cohorts as they developed their PI as part of their professional socialization experiences.

An important expectation of what SI suggests is identity theory and how it relates to my research is worth highlighting here. SI identity theory emerged from original work by Stryker (1968), which summarised succinctly, suggests that 'society' impacts 'self' while in turn 'self' impacts 'society'. In doing so, he introduces the concept of 'identity salience' defined such that within situations, there is the likelihood that any one of a number of identities might be activated. This is based on the premise that people are seen as having multiple identities, theoretically as many as they have roles within their lives (Serpe and Stryker, 2011). Sabel et al. (2014) allude to such an issue within their own research within focus groups of medical educators (n=34) from one national academy and the challenges that they face, an issue I return to again later on pg. 134. Thus, is the suggestion from within SI identity theory highlighting that 'having an identity' requires two elements: that people (placed as social objects by others) are assigned position designations and expectations to them within society and that these people *internalise* these designations and assigned expectations (Serpe and Stryker, 2011).

Carter and Fuller (2016) provide a helpful synthesis of current thinking that reinforces the landscape of SI described by Serpe and Stryker (2011) above. In bolstering the same evidence base, they move on to suggest possible future directions for self and identity within the SI field. In particular, they suggest a gap within the literature that might be possibly addressed in some small way by my research. Correctly, they note (although the basis for their whole review is not explicit) that within SI identity theory, roles and how identities operate to motivate behaviour during interactions, has remained more theoretical than empirical; a cumulative research area programme is yet to emerge in this area. While I am not in any way suggesting my study is a programme, it does perhaps serve as a future primer for such, but I would aim to return to such discussions within chapters five and six of my writing, dependent on the emergence of my findings as they arise.

Accepting the literature's expanse, I have briefly discussed influential key works to synthesise assumptions that are relevant to addressing the research question posed by my study around the barriers and enablers towards a GP trainer's professional identity. Highlighting theories both at the meso and grand stage of construction if one accepts such constructs as framed by Crotty (1998), it is now important to examine more specifically those that exist within the world of the health professional and the doctor-teacher. It is to this I now turn. However, I begin with a section that first charts the influences of policy and practice on the GP Trainer as this has important contextual and explanatory terminology relevant to my research.

2.4 GP trainer policy influences

In order to understand the emergence of the GP trainer and the influence of policies that effect such a role, one needs to understand the origins of the GP within medicine. Before 1858 the health care systems of the 16th – 18th centuries primarily viewed a medical practitioner as, '...anyone whose living was derived largely or wholly from the treatment of the sick, regardless of title, background or education...' (Simon, 2009, p.2). The resultant occurrences of the time, therefore, being that anyone from the 'wise woman' of the area, to the clergy or the local shopkeeper, could partake in such services.

In parallel over this time, with somewhat earlier beginnings in the 1500s (The Worshipful Company of Barbers, 2000) there was the division of medicine into three main specialities: the physicians, the surgeons and the apothecaries. By the 1900s, the physicians were viewed as the highest standing of the medical professionals, often possessing a university degree in medicine (MD). The Guild of the Barber Surgeons broke away from the Worshipful Company of Barbers with the Royal College of Surgeons (RCS) formally created in 1800 (RCS, 2003). Surgeons required an entrance examination to the college but did not have to hold an MD initially. In comparison, the apothecaries were medical professionals who formulated and dispensed medical materials to physicians, surgeons and patients - a role now served by the pharmacist. In addition to these responsibilities, the apothecaries provided a range of other services from midwifery to surgical interventions, leading to the name 'surgeon-apothecary' and more laterally 'general practitioner' (The Worshipful Society of Apothecaries, 2000).

This control over medical qualifications subsequently led to a series of debates and challenges with GPs often holding dual qualifications in the License of the Society of Apothecaries (LSA) and RCS examinations, but not being viewed as the 'pure surgeons' who worked within hospital settings. This promulgated the emergent hierarchy of the Fellow of the Royal College of Surgeons (FRCS) status for those of 'pure surgeon' status. Concerns of holders of any or no medical qualifications (so-called medical quacks) ultimately led to the Medical Act of 1858 and the foundation of the General Council of Medical Education and Registration - later to become the General Medical Council (GMC) (Simon, 2009).

Irvine (2006) recounts how the 1858 Act signalled the beginning of a long run, lasting just over 100 years, during which the medical profession reached the zenith of its independent power and public standing. It was during this time that specialist practice blossomed, and general practice became embedded as the foundation of primary care in the UK. The National Health Service emerged in 1948 (Simon, 2009) and with it, clarity in arrangements of the three-part structure of the GP, the community and the hospital-based settings of the NHS as we, perhaps, know it today.

It is worthwhile mentioning, however, that despite this evolution over time, for much of the early stages, concerning *being a GP*, there existed no specific training for general practice. A doctor could enter into general practice as a fully-fledged GP after one pre-registration year based in a hospital and a one-year post-registration training period (Simon, 2009). Thus, young GPs were poorly prepared to manage the exacting range and depth of the problems encountered in the community. Unsurprisingly perhaps, GPs were therefore still considered as of lower standing than their hospital colleagues, and in the first years of the NHS many were single-handed (Berger and Mohr, 2003), often working from their own homes, with partnerships being of relatively small numbers, i.e. 2-3 partners at the maximum.

Given this position within the medical professional 'hierarchy', a tide of opinion arose that GPs had no specific college or academic body that represented their interests within the NHS, despite being the largest group of medical personnel within Britain. Thus, 1952 saw the emergence of the Royal College of General Practitioners (2012). The RCGP paved the way through undergraduate and postgraduate recommendations on teaching and training such that general practice could be taken seriously as a specialty. By 1968 (Blackburn), a compelling argument was being made for the identity of General Practice as a separate discipline within

medicine, requiring its postgraduate training be organised by GPs. Eventually, by 1976, Parliament completed legislation making vocational training a requirement for any doctor seeking to become a principal in general practice and by 1981, vocational training had become mandatory. This set the scene for the future whereby every trainee GP had to undergo a 3-year training programme, 1 year of which was spent in an approved training practice with a personal GP trainer.

Thus, the status of the GP trainer is unique in comparison to those of clinical teaching counterparts (e.g., consultant surgeon or physician) in that it is embedded within Parliamentary Acts (Horder and Swift, 1979). To clarify, in order to become a GP, *specifically* what emerged was a training scheme structure enabled by the revised Vocational Training Act of 1979. It is acknowledged that prior to this, a doctor could go directly from gaining their medical degree to practising, independently, as a doctor in the community. In contrast, for example, the surgeon, who requires further training and qualifications before this would be allowed. Thus, with the 1979 Act, arose a specific legislative requirement such that not only does one see the arrival of a then clear GP training pathway, but in conjunction, the influence of policy and practice on the GP trainer identity.

The enforcement of this legislative process thus required the establishment of a regulatory body for training (Hasler, 1989). This was stipulated initially by the Joint Committee on Postgraduate Training for General Practice (JCPTGP). In addressing my research question, it is helpful to be aware of the past decisions and guidelines created by the JCPTGP as not only might this have an effect on some of the GP trainers in the past, but the roots of these decisions may have had influences on how future policy emerges. However, it is noteworthy that despite these being the guidelines formulated, such that the GP who sought to seek appointment as a trainer would be awarded this status, if both they and their practice embraced a number of criteria (JCPTGP 1998, 1992, 1985, 1980, 1976), at no point during any of the reiterations of these recommendations and revisions is there an evidence base for the criterion purported. Indeed, at the time of these being constructed, there are no descriptors of any apparent methodological approaches being taken into account in the construction of these criterion sets. Thus, one is left to assume, that they were effectively based on rhetoric, personal opinion and the prevailing views of a core set of GPs at the time.

Opinion aside, these criteria and guidance were enacted at a more regional level by the use of locally constructed bodies (deaneries) whose role is to support and facilitate educational governance (Sandhu, 2012; Lister, 1994). Time, however, sometimes brings change, at the turn of the millennium, there began to emerge indicators of more distinct benchmarks. The JCPTGP (2001) recommendations become sharper on the approach used to select GP trainer criteria as well as highlighting the influences created by the 1997 NHS (Primary Care) Act. More specifically the JCPTGP are clear in that they ask deaneries to act on its behalf in the selection of GP trainers, as well as their practices, although they accept ultimate responsibility in the appointment of this trainer role. They proceed in the same recommendations to highlight that deaneries should continue to develop ways to evaluate the characteristics required of the trainer to determine their suitability, but also indicate that these characteristics are flexible and positioned for the deanery to decide (JCPTGP, 2001).

Moving forward, one saw the replacement of the JCPTGP by the Postgraduate Medical Education and Training Board (PMETB) (Brown, 2005) with a change in training focus at that time. In what ultimately was a seismic shift, the implementation of Modernising Medical Careers (MMC) (Department of Health, 2003) occurred. This document was the response of the four UK Health Ministers to the consultation on ‘Unfinished Business: Proposals for reform of the Senior House Officer (SHO) grade’ (Donaldson, 2002). The key principles enshrined within this set out to ensure, amongst other things, that the end product of the training process, whether a hospital doctor or a general practitioner, should be a high-quality, well-trained and accredited doctor who can deliver the care and treatment patients need in the modern NHS. They support this by highlighting that the training must be buoyed by strong educational management and underpinned by skilled trainers. Thus, saw the subsequent implementation of changes in both postgraduate training programme structure and nomenclature, in direct liaison with the GMC. This resulted in a move from the concepts of the pre-registration house officer (the junior doctor in the first year after graduation, working towards full GMC registration status) and SHO roles to a two-year Foundation Doctor status (Islam et al., 2011).

Following on from two years of posts as a Foundation Doctor, as a result of the changes led by the MMC, clinicians would then enter a period of specialist training, which included GP training, i.e., the GP Specialist Trainee (GPST). The length of this training was left to agreement between the PMETB and the respective royal college, in this case, RCGP. The

ultimate aim of this training is that the trainee works towards the acquisition of a Certificate of Completion of Training (CCT). In the context of my research, a fully qualified and independently working GP. Thus, the scene was set for the changing landscape of the GP trainer / trainee into the new millennium.

The RCGP (2007) however, as a body, were not necessarily surprised nor unprepared for these changes influenced by MMC. As accounts above have shown, there was already a long history of the provision of recommendations for training conditions for trainers and trainees alike (JCPTGP, 2001). Thus, while implementation of MMC meant alignment with one core set of guiding principles for all types of postgraduate training known as The Gold Guide (Oxtoby, 2008), there existed already a well-developed and robustly articulated curriculum and GP trainer selection process with which to influence and direct.

However, Kibble et al. (2009) remind one that the role of PMETB was to influence and direct by guaranteeing that the standards of postgraduate medical education and training were consistent and clear across deaneries. Their robust analysis of the entire 22 deaneries within the UK demonstrated that at that time, all deaneries utilised a process that mirrored the need to adhere to the Quality Assurance Framework ascribed by the PMETB (2005). Conversely, the analysis also noted that there existed considerable disparity between deanery bodies with respect to the application processes and information required to be a GP trainer. The authors culminate their work with a suggestion on both a standardised UK application process, as well as noting the already UK wide trainer call for the GP trainer approval process to be focused on more formative and educational areas of practice rather than being an ‘inspection’. While PMETB has been transformed yet again since this time as outlined below, whether the approval process is something that remains as a barrier to becoming a GP trainer is an area my research seeks to revisit; albeit with the voice of identity theories attuned.

Thus, transforming again, the PMETB as an independent organisation has now merged with the GMC (Department of Health, 2003) to govern under one joint body. This merger has created the current climate and policy setting agendas of more current GP trainer environments. This most recent and considerably comprehensive review has been produced bearing in mind the needs of patients, trainees and trainers alike (GMC, 2017). Driven because the needs of patients and service providers are changing, life expectancy is

increasing, rapid developments of new technologies, pharmaceuticals and IT systems are emerging. Thus, is recognition of the requirement for future doctors to adapt to this rate of change by having the flexibility to acquire new skills, change careers and participate in career-long learning (GMC, 2017). This report indicates a need for ongoing change based on 19 key recommendations. Of these, and most relevant to my research, is the acknowledgement that curricula and training pathways outlined, should be developed by the appropriate Medical Royal College in collaboration with educational commissioners and other stakeholders and submitted to the GMC for approval. Also of importance, is the requirement to ensure that in introducing longer placements for doctors in training, they should work in teams and with supervisors, including putting in place apprenticeship-based arrangements that one is aware of elsewhere (Boudreau et al., 2014; Eraut, 2004).

So far, I have provided a critical historical narrative that brings to the present, the GP trainer, as they are currently positioned within the UK. One can thus hopefully appreciate some understanding of the complexity that contributes towards the PI of the GP trainer from within UK policy alone. Looking out with the UK, similar histories can be seen played out in differing countries worldwide, although none, perhaps, with such complexity or with their origins so far back in time. Whilst no two countries have the exact same set of arrangements with respect to the construction of postgraduate GP (family medicine) training, the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) has established a clear set of standards for postgraduate family medicine education (2013) with the primary aim to provide overall quality improvement within GP delivery of services and education. Constructed via a large working party group, what is notable is the specific credence given to the GP trainer throughout their recommendations, including the articulation of how to appoint a trainer, as well as trainer obligations and development (WONCA, 2013)

Thus, worldwide, we hear from strong and persistent arguments that abate from the United States about the essential need of primary care past (Starfield, 1994) or present (Hughes et al., 2015) or likewise acknowledge the ongoing concerns of our European counterparts regarding possible actions to strengthen GP life (van der Horst and de Wit, 2020; Michels et al., 2018; Zarbailov et al., 2017). Ultimately, however, these policies and debates centre around the need for a set of practitioners who both understand the complexities of medicine

with respect to being community-based, as well as how to support the novice professional develop their own set of knowledge, skills and attitudes.

While I will argue that GP training and trainers have always had such arrangements in place and at the forefront of their minds, how policy and history have led to the shaping of the GP trainer identity has always been a powerful influence in the background. This literature section aimed to critique the historical emergence of policy derived from its origins in society, the onset of the 1858 Medical Act, the emergence of the RCGP and subsequent provisions construed from within a variety of training bodies, culminating in the current RCGP / GMC arrangements within the UK. Having thus provided a summary of the political climate and critical policies that have directed the shaping of the GP trainer I now turn to focus more specifically on that which has moulded the PI formation of the GP trainer.

2.5 Professional identity concerning the GP trainer

Boendermaker et al. (2000) set the scene at the beginning of the millennium with a focus on the qualities of the GP trainer. They highlight a gap in the literature utilising a defined methodological approach via focus groups and a Delphi technique. Their emphasis, however, is positioned on traits of the trainer within a psychologically constructed framework rather than on the concept of identity formation and what are the influencing factors that enable a GP to become a trainer. They suggest traits such as teaching attitude, teaching knowledge or teaching skills are the core characteristics of competent GP trainers. Likewise, Piercy and Dale (2002) follow a similar approach, albeit their analysis focuses on the GP trainee's perspective. They allude to the importance of the relationship between the GP trainee and trainer, seeing it as a positive aspect, as well as the influences of the GP practice as a whole. Yet their methodological approach remains unclear and unexplained within the text as they defer their explanations to another paper that was never published.

Traits of the GP trainer remain an influencing theme within work that does have a more transparent methodological approach. Starr et al. (2003) explored United States (US) physicians' views via focus groups (a cohort totalling thirty-five) who have a keen interest in teaching. Their data analysis elicited a number of key themes, albeit based on a mixed-method approach whereby the elements were identified based on numerical frequency via independent consideration and ratings. Their findings suggested that the integrated identity

of the physician-teacher (i.e., being a physician means being a teacher), a sense of conscientiousness to teach and an appreciation of teacher roles as clinical experts in primary care were all important within their PI. Starr et al. (2003) suggest these latter themes were new at the time of writing, in addition to other pre-existing themes outlined previously in social science literature specifically: respect to intrinsic fulfilment, knowledge and skill about teaching, the significance of extrinsic rewards and the worth of social groups, which they also identify within their work. A limitation of this study was, however, the exploration of these themes concerning identity per se and they instead return to a positivist approach whereby they suggest that future work should consider the usefulness of teacher identity scales.

The development of medical teachers pedagogically, but not through identity, nor necessarily GP trainers is an issue that pervades through the early millennium. MacDougall and Drummond (2005) explored ten medical teachers' learning histories from several specialities including paediatrics, psychiatry, gynaecology, surgery, medicine, radiology and public health (but none from General Practice), through semi-structured interviews, supplemented by pictorial metaphors, utilising an autobiographical outline. There emerged four themed areas: attainment of educational knowledge and skills, demonstration and practice of teaching skills, inspiration and motivation of teachers and restraints on teaching and learning. The work is limited, however, by the fact that no GPs are involved, nor is there any analysis explicitly performed to identify theories. In direct comparison, however, Waters and Wall (2007) do concentrate precisely on the motivations of GP trainers as teachers using a questionnaire design. Although this was applied to a cohort of 360 GP trainers within the West Midlands Deanery in the United Kingdom (UK) and was piloted, it failed to indicate how the questionnaire descriptors emerged from the literature. While acknowledging this, it does highlight several themes that might mirror my research and produce corresponding links. Specifically: the trainer not being understood by their (GP) partners or viewed as their trainer role peripheral to core work, the intrinsic pleasure of involvement in education, the satisfaction of having skills and knowledge about teaching, the awareness of fitting into a group of teachers, and the feeling of a purpose of duty to teach medicine, as well as to practise it.

One has to look externally from the medical hegemony to note the first origins of establishing a professional identity as opposed to traits and attitudes. Higgs and McAllister (2007) in their work with speech therapists determine a phenomenological approach through narrative

enquiry to explore the stories of five females within the profession in Australia. The rigour of their work allowed them to develop a model of the lived experience consisting of six dimensions. They described these dimensions as a sense of self, a sense of agency as a clinical educator, a sense of *being* a clinical educator, a sense of relationship with others, pursuing dynamic self-congruence and one which focuses on growth and development. However, while this may have relevance for my study, it does not explore GP trainers explicitly, nor does it explain the importance of the dimensions concerning professional identities by itself.

Professional identity is however, precisely delineated by Beaulieu et al. (2008) in their work which focuses on the recruitment of GPs to the profession more generally as well as other specialities. They recruited four different medical schools in Canada as case studies to explore accounts of roles and tasks of the family physicians as held by future specialists and family physicians and their clinical teachers. Their conceptual framework was one specifically developed for the analysis of vocations and utilises a case study approach similar to my research. Their report, however, is vague, although they acknowledge this weakness, particularly in respect to triangulation, themselves. Their results are focused on recruitment issues rather than training issues although one might expect that similar themes of their findings may emerge in my study, such as what being a family physician is all about, family medicine in danger of extinction, and the generation gap between fledgling family physicians and their educators.

The GP as an educator has been a recurrent theme within the literature. Several researchers (Lyon-Maris and Scallan, 2013; Kibble et al., 2009; Wiener-Ogilvie et al., 2008; Pitts et al., 2005) utilise variations on the themes of questionnaires and semi-structured interviews to explore GP's attraction to training or the interplay associated with training standards. Pitts et al. (2005) obtained questionnaires (n=49) from non-training GPs in The Wessex Deanery to explore non-GP trainer's views on taking on a GP trainer role. Their findings suggested finding the time to train coupled with competing practice commitments, practice accommodation for the trainee, negative attitudes of the partners and possessing a personal qualification of the Membership of the Royal College of GPs (MRCGP). All proved barriers to being a trainer, albeit these numbers were not of statistical significance nor analysed in such a manner.

Important to my research, Wiener-Ogilvie et al. (2008) sought to explore GP trainers' views on proposed changes to the then newly introduced GP trainee scheme in Scotland. Their main aim being to identify the types of support mechanisms available to the trainers locally. They sought the view of GP trainers, Scotland-wide (n=39), via a semi-structured interview process. Their findings (elucidated via an unspecified coding analysis) suggested that there were a number of reasons GPs became a trainer, there were opportunities for trainers to discuss their own training needs and education, and that resources were available for them locally. Although this research did not focus specifically on PI, it does highlight areas that one might expect to uncover in my research approach, albeit that my methodological standing will be much more explicit.

In a differing approach, Kibble et al. (2009) thematically analysed the applications forms used by GPs to apply to a deanery for a GP trainer post to identify common areas. In this case, however, the themes were areas common in documentation such as trainer's demographic details, employment information, training and experience and items related to their GP practice, rather than anything specifically related to PI. Likewise, Lyon-Maris and Scallan (2013) distinctively sought completion of a questionnaire from a lead educator (n=17) in each deanery of the UK. They indicated many areas of baseline procedures across GP deaneries whereby there is a suggestion of harmonisation of enablers to GP training practice approvals such as the length of time a GP trainer should first be qualified as a GP, being a sole trainer within a practice and the requirement for compulsory academic qualifications, amongst others. While these areas have significant potential to emerge in my research, one must be mindful that this is a small-scale survey, including the use of a single questionnaire submission to represent the whole of Scotland. Therefore, not only do these works hold no power concerning their validity, but also bore no relevance to PI or its theories.

Similar to the GP being an educator, the educational climate of GP teaching is also regularly explored. The majority of the texts (Cantillon and de Grave, 2012; Guldal et al., 2012; Smith and Wiener-Ogilvie, 2009) however, focus on relations that exist between the GP trainer, their students (medical students and/or GP trainees) and the educational climate. Smith and Wiener-Ogilvie (2009) conducted focus groups with GP trainees in the south-east of Scotland (n=77) to describe the learning climate of their training practices. Drawing on a clear analysis that incorporated an independent GP educationalist for face validity, they described

five central themes that emerged from their participant data. Namely, that the learning climate concerned: matters relating to the training practice, issues related to the GP trainer, topics related to learning, issues related to stress and finally, issues related to tutorials. Their discussion of these findings centres on supporting an educational theory framework of learning in the workplace that was reflected through Knowles (1984). They conclude by suggesting that during the reformation of GP training that was occurring during that time, it provided an occasion to shape a quality management system that was based on evidence of learner encounters of the educational climate. I note they also felt the need to recommend a higher weight being placed on learner feedback with a move towards a consumer-orientated replica of medical education. However, I think that the current time period of my research lends itself to a return to such earlier notations of educator's requirements. I would suggest that while learners' needs are important, there is a changing landscape that requires a refocus on GP trainers' needs and developments. Otherwise, there will be no-one potentially left to train the trainees, a point that this research positions itself to address.

In contrast to the trainee's perspectives of the learning environment, Cantillon and de Grave (2012) set out to explore the opposing side of this relationship. Their 2012 paper draws on a larger body of work using a mixed-method approach (phenomenological interviews, concept mapping and video stimulated recall) to present data on GP teachers' pedagogic and context knowledge. While acknowledging this was a small-scale study of GP teachers linked to one medical school in the UK, they suggested the salient elements that emerged consisted of knowledge about circumstances (learners and educational environment) and pedagogy (teaching, explaining, using questions and dealing with learner error). This case study approach might have utility and parallels with my research. However, one must keep in mind that within this research the focus is on a GP as a teacher of undergraduates and not, as my study will show, experiences associated with postgraduate training and more so, elements that may contribute towards the specific concept of PI formation therein.

Unlike the small case study of the GP as an undergraduate teacher, Guldal et al. (2012) do, however, provide a compelling argument by drawing on a broad European audience about the educational expectations of GP trainers. Utilising questionnaires to target GP trainers (n=61) across Europe they briefly describe how their open-ended questions were analysed by empirical thematic analysis using a grounded theory approach. Critically, however, they proffer no more detail than this. This noted, their key recommendations do add significant

influence on some of the expected themes that I might expect to emerge from my research, especially the commentary that,

‘...one of the biggest threats to proper training is the working conditions of practice-based trainers. These trainers are facing a growing workload due to other obligations and such problems cannot be addressed by ‘training the trainers’ programmes...’

(Guldal et al., 2012, p. 235)

Such interpretations lend themselves to consideration given that, while I retain an open mind to positive change, I highly expect that the current climate of the GP workforce within the UK and Scotland (Doctors.net.uk, 2019; The Kings Fund, 2017; RCGP, 2015b); to influence my own research findings. Drawing on my personal experiences as a GP teacher and trainer, I envisage that the influences of the political environment and labour force market might well emerge as a salient theme within my findings.

Finally, within this section of the literature, there is the emergence of evidence that perhaps, unsurprisingly, begins to focus specifically on GP trainers’ views (Ferguson et al., 2014; Wiener-Ogilvie et al., 2014) and clinicians who *become* teachers (Cantillon et al., 2016). The former, explored via telephone interviews and focus groups, the perceptions of assistant GP directors and GP training directors (n=25) within Scotland. They indicated areas of potential influence for the future GP trainer such as: changing GP trainer role, the flexibility of training and the changes in GP careers. However, one must be cautious of the interpretation given that the methodological approach is poorly defined and not evidenced.

In comparison, the latter is a much more robust piece of work. Drawing on semi-structured interviews with sixteen physicians in Ireland, it centres on communities of practice theory (Wenger, 1996) albeit drawing out essential elements of teacher identity. Importantly perhaps they suggest that becoming a teacher is,

‘...a social process of becoming recognised as a competent person in relation to planes of accountability, where emergent teacher identity and practice represent the teacher’s negotiation of the tensions in a political landscape...’ (Cantillon et al., 2016, p.1004).

Being both a GP and a teacher is an area of discourse that continues to dominate the most recent literature. Somporn et al. (2018) constructed a narrative review to examine ‘stakeholder experiences’ of rural, community-based medical education (RCBME) programmes internationally. The authors utilised a symbiotic model of medical education as an analysis framework to examine all relevant articles after 1970 (n=52). Their findings focus on how medical students provide social capita to rural communities and the associated financial costs, not on the GP educators nor on PI per se. However, I do note that of particular relevance is their suggestion that,

‘...participation in an RCBME contributes to the development of a student’s professional identity as a clinician, a GP and a rural doctor. Some evidence exists to demonstrate that mentorship also shapes students’ personal and lifestyle expectations...’ (Somporn et al., 2018, p. 799)

These findings might, therefore, give an indicator of the types of areas that could perhaps arise as the GP trainers within my research articulate their own experiences, rural or otherwise, that have contributed to their PI of their current status. This status is something that can be seen echoed in work that Reid and Alberti (2018) undertook by applying a phenomenological approach to two cohorts of medical students (n=14) to examine perceptions of general practice as a career. Whilst small in terms of numbers (2 focus groups), their findings suggest that the concept of being a GP lacks prestige and challenge. Some of these are feelings are adopted by the medicals students on the basis of internalising their role model’s perceptions and values, fuelled by a hidden curriculum. I do question whether this might emerge within the themes of the perceptions of my GP trainers or policy documents that underpin their role in my research.

Similarly, Harris et al. (2019) conducted interviews with young doctors who were making decisions about which medical career to enter. In their qualitative analysis (n=24) they note that GP placements significantly influenced their career intentions but had the participants concerned about this same level of challenge and prestige, as well as the loneliness of working in general practice. How a GP teacher or trainer might role model these issues, be that positively or negatively, is a matter that could influence PI formations of future generations.

Most recently, Jackson et al. (2019), in their robustly conducted systematic review, sought to conduct an integrative approach of international literature on GP supervisory relationships. Their results (n=49), talk to the need of a working alliance between the GP trainer and trainee, albeit that the one-to-one relationship as it currently stands, is very positive. However, they speak to the fact that there needs to be an appreciation of the multiple roles and competing priorities of both trainee and supervisor, issues that might ultimately change with rising GP workloads and community medicine transformations; something that my research seeks to articulate.

These same issues are also illustrated via work that is embedded within an Australian context. Garth et al. (2019) sought very specifically, from within a communities of practice approach, to seek how GP trainers' PI was experienced. Their findings (n=15) highlight how the GP trainer requires supervisor skills, an assigned role, meaning in this role and balance between the supervisory role and their role as a clinician. I would expect my findings might echo similarities here, however, given the context and policy-driven focus from within a Scottish / UK environment, as well as a differing theoretical lens via SI, I also expect a unique set of findings to likely emerge.

Latterly also, Ingham et al. (2020), again with an Australian context, conveyed a cohort of trainees and trainers into seven focus groups (n=75) to explore what is 'safe supervision' as new changes in national arrangements are being proposed. Whilst methodologically the data collection and analysis approach are reported elsewhere (although not clearly outline), their findings once more suggest an interplay between the trainer / trainee relationship, clinical commitments, supervisor skills and motivation and logistical/funding commitments. Within my Scottish context one might expect similar findings woven within a PI framework or my research.

Thus, I note that currently, much research within PI related to the GP trainer at the beginning of the millennium commences with a focus on qualities or traits of the educator situated within quantitative measurements (Boendermaker et al., 2000). There then exists a move towards more qualitative techniques and exploratory methods, not always centred on GP trainers, by the middle of the first decade (MacDougall and Drummond, 2005). PI emerges explicitly in this period also, with broader views being explored within Europe as a whole. Latterly there exists evidence of work more specific to Scotland (Wiener-Ogilvie et al., 2008)

and Ireland (Cantillon and de Grave, 2012) as to how the GP trainer of the future might be influenced. None of this, however, explores in any great depth the more current and modern times of the GP trainer, with PI formation specifically only beginning to emerge recently. Bearing this in mind, I suggest this positions my research ideally to examine the current state within one specific area of Scotland. However, before I describe in detail how this has been approached, it is also helpful to keep in mind how PI is situated within the field of medicine as a whole. It is to this I therefore now turn.

2.6 Professional identity formation and medicine

At the turn of the millennium Stone et al. (2002) remind the researcher of work that described the role of the clinical teacher composed of being: a clinical supervisor, an instructional leader/scholar and a role model. Espousing literature of PI formation, they suggest that the PI of the clinician-educator requires a need to develop both externally (e.g., new information and new social sets) and internally (i.e., subjective self-conceptualisation) in order for the teacher neophyte to mature into the professional. In conducting a small-scale study of semi-structured interviews of preceptor physicians (n=10), within five medical schools in New England, they thus sought to examine the factors that these preceptors thought important to their identity as teachers. Utilising a robust coding framework, while data saturation is presumed but not specified, the findings suggested that there were four key elements of important influence: humanitarianism, familiarity with adult education principles and practice, an appreciation for both the pros and cons of teaching and the image of self as a teacher. Their discussion culminated with the suggestion that in considering faculty development, aside from a focus on specific teaching and behavioural skills, there was a need to ensure that there was a fostering of PI of the teacher. In addressing the details of my research question, I would hope that such areas of discovery might also emerge from within my data. Albeit that my context will look more specifically at the PI of participants that are not only GPs as opposed to physicians, but UK (indeed Scottish) based, rather than in the United States of America (USA).

The USA at this time, appears to hold significant influence concerning examining PI formation within healthcare. Johnson et al. (2006) extend the arena of this research by investigating the PI of veterinarian surgeons and the salience of their occupation with respect

to their workplace environments. However, one must bear in mind this was a quantitatively driven data analysis of vets (n=1,750) utilising recognised item scales. What is important to consider are the findings, drawing on the fact that GP trainers, to some degree, also work in organisations of similar structures. In this study's case, there are no direct links with the concept of the professional as a teacher. However, what is noteworthy are the significant results suggesting that for professionals, identification with their organization is less likely when the organization (practice) is not fundamentally connected to their profession. This may be useful to bear in mind with respect to my research given that there is a tangible link between the GP trainer and the practice to which they belong, often the trainer being one of the practice GP partners, thus holding overall responsibility for that organisation.

This responsibility and linkage with the workplace are something that is reiterated during this period within medicine also. Staying in the USA but now incorporating primary care, as well as surgery and radiology, Pratt et al. (2006) sought to examine identity dynamics within the shifting timespan of clinicians in their respective residencies (trainee years) of their chosen specialities. In a longitudinal process over several years to exiting as a consultant (programme specific), they returned to interview residents (n=29) on emergent aspects of PI, organisational identity, daily activities and training, and relationships. Their clearly delineated coding processes summarised an interplay of work and identity learning cycles that led to a personalised customisation of their PI. What the authors highlight in their discussions is that there is a chemistry between the work environment, career/role transitions and socialization. The authors argue amongst other things, that in terms of professional training and management, to understand what trainees are 'changing into' it is critical to know what they are 'changing from' (Pratt et al., 2006 p. 258). Thus, not only is this something that the GP trainer may also have to bear in mind and espouse as they undertake a supportive role alongside their trainee, but also, that which emerges from assuming their role as a GP trainer, where they undergo their own PI transformation. Whether or not this arises within my research is something that I need to be sensitive to within the data.

This longitudinal approach to research is something which is also positioned strongly from within the work of Monrouxe (2010, 2009). Over a three-year period, reports from 17 medical students were analysed as the students recounted personal experiences during their initial three years at medical school. The narrative themes suggested six dominant discourses were constructed around what was happening as a student becomes a doctor, i.e., privilege,

gratitude, healing, certainty and the 'good' or 'detached' doctor. The students' accounts, along with the author's conclusions suggest a complexity within PI formation, one that is influenced by a number of preconceived ideologies held prior to attendance at medical school. Whilst my research will not utilise the same methodology, it may well evoke findings that reflect similar issues.

In the same time span but from within an opposing approach, Crossley and Vivekananda-Schmidt (2009) sought to operationalise a tool that monitored PI formation via a cross-sectional analysis of medical students (n=1334). The tool was synthesised via mapping of a spectrum of health care professional themes, with ten varying professions contributing to the questionnaire constructs initially, albeit these specific backgrounds not wholly articulated. The results alluded to the fact that the tool could be used for monitoring PI curricular outcomes (not individual ones), but they noted that students with more prior experience in health roles, advanced more significantly. Whilst these results are quantitative in nature, I might expect that qualitatively, my participants could speak to how their health care or GP experiences from within early medical days might hold sway over their future PI formations.

Whilst Crossley and Vivekananda-Schmidt (2009) speak to the utility of curricular PI tools rather than the individual per se, Weaver et al. (2011) highlight the importance for PI formation with respect to that individual being 'part of a team'. The latter authors' work centres on qualitative interview data gathered from early years experiences of Australian medical students (n =13). In what appears to a trustworthy piece of research, they highlight that from within their context, two primary components (professional inclusivity and social exclusivity) contribute to a strong sense of PI. What they therefore echo, is that as one assumes a chosen PI, by its very nature the person hopes to become more involved with the same types of people performing these roles, in thus doing so, they might well find themselves removed from other settings. Such a balancing act, akin to personal/professional life equipoise is something that is highly likely to be espoused in my study - an issue I will attempt to address as I progress reflexively.

Returning to trustworthiness and robust analysis, Jochemsen-van Der Leeuw et al. (2013) very clearly outline the attributes of a clinical trainer as a role model in their systematic review. Whilst bearing in mind that from within the articles examined (n=17), none are drawn from the UK, and only one from a family medicine background, their results suggest

that the attributes required can be placed within three categories. Named as being 'patient care', 'teaching' and 'personal' qualities, their aim was to help identify attributes that trainees might recognise as aspects of the trainer's professional behaviour to imitate. Such findings thus talk of the need for the GP trainer to both role model such qualities as well as articulate them in the resultant interviews I aim to undertake with them. How much of this will also be reflected within policy documentation might also be uncovered.

Early writing (Monrouxe, 2009; Pratt et al., 2006) has already indicated the importance of longitudinal research in contributing to PI formation evidence. This is an area that continues to have additions to the discourse; Boudreau et al. (2014) do such in 2014. In the latter authors work, their primary aim was to understand the apprenticeship learning process. They did this carefully by dissecting the experiences of students (n=24) and teachers (n=3) involved in a physician apprenticeship course over a four-year time span. In a mixed methodological analysis, their results suggested that salient features of a successful apprenticeship consisted of access to authentic clinical experiences as well as the provision of a safe environment within which critical reflection was enabled. Teachers specifically within these settings have qualities that were illustrated as being akin to a parental role with the concept of students entering a 'kinship' of physicians emerging. Ultimately, the teachers experienced a rekindling and endorsement of their commitment to the ideals of medicine. Drawing on my own experiences to date, one might, therefore, expect that narratives that evoke issues centred around the trainer's relationship with the trainee and how the training practice espouses such a safe environment might be elements that emerge in the findings of this research.

By the year 2014, one could argue there emerges as a future explosion of PI literature within medicine as this period evolves. This was highly likely stimulated by the work and arguments centred around signposting by Cruess et al. (2014), viewed by many as key authors in this field (The Association for the Study of Medical Education, 2013), and as emphasised by their personal viewpoint article, that medical educators should reframe medical education to support PI formation. Whilst this was an espoused perspective in nature, the authors draw on, what appears to be, many years of experience supplemented by high-quality research that had focussed on professionalism and its teaching to date (Hodges et al., 2011; Cruess et al., 2000; Cruess and Cruess, 1997). In subsequent years they proceed to outline a schematic representation of PI formation (Cruess et al., 2015) that heavily draws on

concepts of how an individual moves from legitimate peripheral participation in a community of practice to full participation as theorised by Wenger (1998), and its suggested placed upon Miller's triangle (Cruess et al., 2016). The authors acknowledge that this is a model driven by experiences and theories to date, rather than one proven via results (Cruess et al., 2015). Indeed, this is the intention of the work, to set future directions for research via this model, as new findings evolve. I would suggest, that in part, one contribution to this might, therefore, emerge from the findings I sought to uncover within the context of my research.

Remaining within 2014 we see too, a revisiting of a classical favourite of medical social anthropology 'Boys in White' via Nunes and de Barros (2014). Whilst the latter authors spend more time explaining the original context of both the work and the background of Becker et al. (1961) per se, Nunes and de Barros remind us that this work retains a sense of longevity partly due to its methodological approach, inclusive of relationships with SI. Whilst I can't foretell how long my research may hold as an original contribution given it is less expansive in nature in comparison to Becker's 1972 book, I would hope its underpinnings retain a sense of authority and rigour that endures.

Thus, we see the scene set for the development and emphasis of PI articles that emerge and develop in this time span. Wong and Trollope-Kumar (2014) perhaps pre-emptive of such announcements had already set in motion and uncovered a richness of data within their own longitudinal research. In their case, they sought to examine the PI formation of Canadian medical students in their transitions from students to doctors via a narrative analysis of reflective portfolio work (n=65). Their results yielded five major themes and sub-themes: prior experiences, role models, curriculum, patient encounters and societal expectations. In examining my research context, I am reminiscent of the fact that some of these areas, e.g., curriculum and societal expectations, might be less well articulated within the experiences of GP trainers, more so because they are sometime now removed from such settings, with no writings to reflect back on. However, how my data speaks to such events, especially perhaps issues such as role modelling and prior experiences, will hopefully emerge in a similar way to the robust analysis that was demonstrated in this work (Wong and Trollope-Kumar, 2014).

Of course, PI formation and exploration is something not just confined to the world of the medical student. Examples of other health and social care professionals that have contributed towards PI formation within the literature can be seen via clinical managers (Spehar et al.,

2015) or occupational therapists (Turner and Knight, 2015). Noteworthy in the former, Spehar et al. (2015) express the difficulties doctors face in balancing dual roles, i.e., clinician versus manager, not unlike perhaps the clinician versus 'educator' role that may emerge from my GP trainer identity research. In the latter, Turner and Knight (2015), in what seems to be a high-quality literature review synthesis, articulate how occupational therapists encounter consequences of issues from within which PI leads them to believe they are undervalued. Whilst being undervalued as a clinician might be less of an issue for my participants, that as the role of a trainer might differ, indeed some GPs do relinquish this latter role, therefore, there may exist articulation of this as a barrier, a reminder of possible responses to my research question that I seek to address.

As described in earlier studies (Somporn et al., 2018; Monrouxe, 2009; Higgs and McAllister, 2007), the processes of narrative research often contribute towards PI literature, especially within medicine. Foster and Roberts (2016) explored the insights of senior doctors (n=12) to understand the development of the individual in becoming a medical professional. Their results talk of the concept of role models framed as 'heroic' or 'villainous' characters depending on whether these influences were positive or negative, respectively. Everyday events described still created emotionally charged and persistent participant memories, more so with negative events, e.g., bullying. I may well come to expect a similar degree of narrative to emerge from my participants, although I would hope that my approach, as will be described later, retains an ethical dimension that allows for a safe space for my participants to articulate such feelings. How positive or negative, and how powerfully they might affect the GP trainer PI, is yet unseen.

The role model is an important determinant of PI that Passi and Johnson (2016) also determine is of significant influence. Unlike the context of senior doctors as above, Passi and Johnson (2016) sought to investigate the impacts of positive doctor role modelling in medical students, as well as understand the processes by which such role modelling brought about any effects. In a robust approach utilising focus groups with medical students (n=52 students), they summarised their themes using grounded theory. Their findings talk of three main role modelling outcomes: the development of professional identity, the development of professional behaviours and the shaping of career aspirations. The authors allude to these processes, perhaps occurring through the curriculum that is being followed. Given that in recent years both the RCGP (2009) and the GMC (2018b) curricula mention the role of the

clinician as a teacher, one has to wonder if this is something that might emerge within the thoughts of my participants, a disparity worthy of exploring.

This integration of a teaching role into one's identity forms the very title of work by van Lankveld et al. (2017). The authors position their argument by suggesting that medical teachers starting out, often view themselves as doctors or researchers as opposed to teachers. The latter authors proceed to apply both figured worlds theory (Holland and Lachicotte, 2007) and dialogical self-theory (Akkerman and Meijer, 2011), to explore how early teachers in the field of undergraduate medical education integrate a teacher role into their identity. Lankveld et al. (2017) summarise that five differing narratives would appear to exist, any of which might be considered a starting place for the identity of the teacher role to exist. I would suggest that such positions may also be akin to ideas expressed from within my research. It is highly likely that some of the GP trainers may begin the processes of becoming a GP trainer by first having had experiences in other teaching roles, such as undergraduate medicine, as indeed did I. How these narratives play into the PI of the GP trainer might, therefore, be considered of some importance.

Like van Lankveld et al. (2017), Browne et al. (2018) sought to examine this transitional state as clinicians move into an educator's role. In the latter case, however, they proceed by exploring senior educators' experiences of achieving the transition into medical education and what helps or hinders the process; similarities thus exist to my study. Browne et al. (2018) did this by conducting focus groups with 15 senior medical educators. The authors applied a specific analytic framework and do acknowledge that their findings are limited by their use of purposeful sampling of fellows from one UK academy, thus experiences of junior doctors were not sought. Whilst small in numbers and not specific to general practice, the framework used suggested four key areas of importance. These include characteristics of self, the situation they are currently in, strategies within education and support. Drawing on my previous experiences as a GP trainer, I might expect some of these to emerge within my own research. However, I would purport that the strategies used by GP trainers and certainly the situation, i.e., the community with a broad-based 'generalist' overview, are perhaps likely to evoke a differing set of findings, thus is the gap I seek to address.

As we move into a new decade, where then does this currently situate us with respect to the PI formation that enmeshes the world of the student, the teacher and the clinician? Cantillon

et al. (2019) in a scoping review of the literature (n=34 research reports) would suggest that the answers exist in clinicians reconciling their identities as teachers with their identities as doctors by juggling the two and finding mutuality between them or merging them into a non-conflicting state. What they do not answer in this work is how this might come about. Indeed, their recommendations suggest that this is an area that future research could explore. This is what my research seeks to do in one small part.

Cantillon et al. (2019) have not been alone in such explorations. Stepping out of medicine directly and into professions allied with it, Gibson et al. (2019) undertook what appears to be a robust systematic review to examine what skills and qualities a clinical educator should hold. Their findings clustered around seven educator skills and qualities ranging from intrinsic and personal attributes, skilful feedback and understanding student expectations, to being organised and holding a clinical role within their educator role. Again, we see this balance of the clinician versus the educator, something I recognise from my own experiences, thus maybe also my GP trainer peers when it comes to eliciting their responses. This has been reinforced by Yin Ong et al. (2019) who did more specific qualitative work, with occupational therapists and physiotherapists (n=39) in Singapore. Once more is articulated this concept of there being shared meanings between clinician and educator roles, although not necessarily a reciprocated verification of their professional identities. They end their work by suggesting for future practice, there is the need to provide educational training as well as on-the-job training, to enhance a clinical teacher's competence and self-confidence, perhaps something that policy in my context may speak more strongly about.

Thus, concerning PI and medicine we see a timewise movement. Whilst not articulated specifically, origins might be first conveyed via original works from the likes of Becker et al. (1961) past and present (Nunes and de Barros, 2014). A sea of change is, however, initiated via Cruess et al. (2014) in a tidal movement to exam not just professionalism but PI in detail. Thus, in the years following, the literature follows such a course via narratives (Rees et al., 2014b) and insights (Foster and Roberts, 2016) that often continue to eddy around the tensions of the clinician as educator versus the clinician as a doctor (Cantillon et al., 2019). How these waters of literature pilot within teaching and education more specifically, this writing now turns towards.

2.7 Professional identity formation and teaching

While nearing two decades olds, within education, Gee (2000) has been a frequently cited paper that purports the notion that identity might be used as a critical instrument for scrutinising issues of theory and practice in education. Bearing in mind that this is one individual's approach, and the author acknowledges this regarding no explicit methodology, what he does do is set the scene for future directions in education. Gee (2000) suggests four ways that identity might be viewed (a state, a position, an individual trait or as experiences). In doing so, he suggests that provision is made for providing new discourses within PI that might empower specific systems of people and networks across a country.

In a parallel discourse during the same period, Beijaard et al. (2000) were also exploring a similar stance on identity. In their setting, however, they took a much more specific approach with a questionnaire study of secondary school teachers (n=80) from the Netherlands. They examined elements of teachers' PI that they selected to describe concerning the teacher as: a subject matter expert, pedagogical expert or didactical expert. Their work suggests that the theoretical distinction between these three aspects of PI might prove useful for investigating teachers' perceptions of their PI. However, they highlight, like Gee (2000) that there is still a long way to go concerning examining PI formation within this expert group. Indeed, like my research, as I will continue to show, neither of these areas have yet to be examined concerning examining PI formation within the GP trainer population.

Moving forward, Thorne (2004) suggests that identity, as ascribed by many theorists, is both a social and psychological construction. Her position, imbued within life story research, more specifically work by Bamberg (1997), concludes by indicating that by studying individuals and their dynamic positions against others, could, potentially, foster identity research. Likewise, but with a much more systematic approach, Beijaard et al. (2004) reviewed the then recent literature specific to teacher PI and highlighted four features (public, private, individual and collective) that they felt were essential in exploring PI.

By 2008 Vähäsantanen et al. being influenced by Beijaard et al. (2004) set to examine teacher's orientations towards their profession, especially regarding what was important within their work, in a cohort of Finnish teachers (n=24) within two higher education settings. In an arguably robust, narrative-based study, with explicit thematic analysis, they

determined that differing work organisations provided differing resources for teacher's PI negotiations. Their conclusions argue that organisational learning and development can be inhibited if an individual develops their knowledge and competence, separate from, and without transfer of, knowledge, within the organisation. As this thesis will later explain, while my research examines the PI development of individual GP trainers, they all exist as part of a larger organisation of professionals with shared and espoused values. Thus, any discoveries made during my research might ultimately bear similarities to Vähäsantanen et al. (2008) and their findings.

Much of the work described so far have acknowledged that they have been small scale, albeit in-depth studies. Schepens et al. (2009) approach the concept of PI from a differing, positivist position. Drawing on a realistic pedagogy of teacher education that is aligned with Beijaard et al. (2004) they used a sample (n=762) drawn from newly qualified schoolteachers in Belgium. Their Likert questionnaire underpinned by a CIPP-model (i.e., Context, Input, Process and Product) was subjected to regression analysis of variance. Ultimately, they concluded that while the form of teacher education played a significant role in predicting the teacher's self-efficacy, professional orientation and commitment were the most important predictors. Thus, it is worth bearing in mind that as I seek to determine factors that might answer my research question, elements such as self-efficacy and professional orientation might, therefore, emerge as being important findings in my context also.

Quantitatively based themes that influence teacher PI is something that is also highlighted in work by Hamman et al. (2010). Examining student and newly qualified teachers (n=221) associated with one large public university in Southwestern USA, they sought to answer what were the dimensions along which new teachers defined themselves in the future. They asked also, how those dimensions might reflect a task versus quality foci. Collecting their data under a questionnaire protocol, they suggested that new teachers' possible selves might be arranged into four main categories, namely: classroom management, professionalism, interpersonal school relations and instruction. The authors do acknowledge limitations of access and availability causing slightly differing procedures gathering data from student teachers than from in-service teachers. This aside, their analysis appears robustly driven. This classification, while not directly transferable to the context of GP trainers, is worth

bearing in mind as I seek to establish what it is that GP trainers might view as being elements of their teacher (trainer) selves, future or otherwise.

Classifications and characteristics of PI continued to emerge within research over 2010 in particular (McGregor et al., 2010; Swennen et al., 2010; Timoštšuk and Ugaste, 2010; Vloet and van Swet, 2010). Many of these drawing on the recent review by Beijaard et al. (2004), they set to explore PI from differing perspectives. Through an ethnographic exploration of seven teachers on an Educational Doctorate in Wolverhampton, McGregor et al. (2010) apply interpretive lenses to reflective narratives. The authors, drawing on Wenger (1998), suggest that their participants transform from ‘legitimate peripheral participants’ to becoming more participatory as researchers (given the nature of this course). However, they also note that these teachers had, until then, a primary focus on understanding about pedagogic thoughts or values and supporting proficiency or knowledge development in learners, something that I envisage will likely emerge from GP trainers during the course of their PI transformations also.

Likewise, Swennen et al. (2010) begins with the work of Beijaard et al. (2004), however, in their context they return to review the literature to answer the specific question,

‘What sub-identities of teacher educators emerge from the research literature about teacher educators and what are the implications of the sub-identities for the professional development of teacher educators?’ (Swennen et al., 2010, p.135).

While their analysis is not wholly explicit, their conclusions do culminate in a useful model indicative of embedded identities. They suggest that the sub-identities of teacher educators are built within the numerous figured worlds these educators belong to, simultaneously and at differing times in their occupations. They articulate that at the centre is the first-order context of schoolteachers, a fundamental sub-identity of teacher educationalists espoused as a foundation of having knowledge about teaching and teachers. Next is a move from first-order teacher to second-order teacher in higher education, reflecting for teachers that inside the larger community of practice of education, the figured world of teacher education holds opposing views from that of primary or secondary education. For some, the context of higher education and teacher education then becomes intermingled with sub-identities of ‘teacher in higher education’ and ‘teacher of teachers’ or ‘second-order teacher’ being available.

Finally, the sub-identity of the researcher traverses the other sub-identities as the ‘teacher educator as researcher’ through scrutinising the teaching and learning of student-teachers, schoolteachers and teacher educators as well as the broader perspective of teaching and teacher education. These connections between the sub-identities of teacher education and the numerous situations to which teacher educators can belong, replicate a structure that is mindful of my GP trainer and research experiences to date. Thus, as I will explain later in this writing, drawing from my personal insider experiences, there are many parallels to bear in mind when it comes to eliciting the responses to my own research.

Timoštšuk and Ugaste (2010) as indicated above, also cite Beijaard et al. (2004) as being influential in their approach. In this case, the former authors elected to use in-depth individual and focus groups with forty-five teachers in initial stages of teacher training at Tallinn University. While being mindful that their theoretical driven analysis utilised learning theory via Wenger (1998) their suggested findings, proffer classifications of PI that have been encountered already. Namely, (teaching) experiences of the world as meaningful, actions related to teaching, belonging to the teaching community and learning as a teacher. The teaching community is a newer theme to emerge from their literature at this point. Concerning my research question and GP trainers, one component of GP trainer training is involvement with GP trainer groups (communities). Whether this proves to be influential or not on their PI and thus as an emergent theme will ultimately be determined by my findings.

By the first decade of the millennium, a consistent theme that permeates much of PI and the teacher is the use of narrative-driven methods to explore PI. One specific example being Vloet and van Swet (2010) who draw explicitly on the symbolic interactionist theory of Mead (1962) as previously discussed. Citing Beijaard et al. (2004) they use a combination of a biographical interview method merged with an animation film, that served as a metaphor for development. Eight teachers from differing postgraduate training courses of one institute (un-named) elected to participate. Alluding to a grounded theory analytical approach driven by underlying additional dual theories, which I view as being overly complex for the number of narratives, they conclude with three predominant findings. Firstly, that identity is formed through an active route where professionals constantly interpret and reinterpret their meaningful encounters from their practice and biography. Secondly, that identity infers an interface between context and person, requiring a sociological as well as a psychological perspective. Lastly, that PI consists of several sub-identities that are more or less in harmony

with one another. Of these, at this point in the research, the latter might have significant implications for my study. Might it be the case that this also exists within my research context, and if so, does an imbalance within these lead to any barriers to practising as a GP trainer? In the current climate of the pressures of the GP trainer and conflicting elements such as clinical and/or other personal demands, this is very much something to be considered.

Consideration, therefore, of how PI within the teaching profession has been drawn together over more recent times has been deftly constructed by Trede et al. (2012). In their systematic approach to the literature utilising a philosophical, hermeneutic approach they ultimately only identify 20 papers within the current literature that addressed their research questions, one of which being, 'What is the relevance of PI'? Their results suggested that there still existed a dearth of literature that addressed such a query that was comprehensively explored through evidence within higher education. Understandably, perhaps, their results suggest that that which does exist was underpinned from a variety of theoretical stances ranging from Vygotsky (1978) and Wenger (1996) through to Giddens (1991) and Schon (1991). Trede et al. (2012) conclude by reminding the reader that PI development might be considered increasingly about being in a multiplicity of worlds or communities where PI and its development is complicatedly situated. Thus, the authors signpost to future research that is upfront and discusses what PI development and its conceptualisation means for educating and developing future professions. My research, I suggest, addresses one element of this gap, albeit small.

Latterly, reviews of the literature following previous decades of singular papers that discuss PI with education, continue to emerge. Similar to Trede et al. (2012) above, Izadinia (2013) in her clearly delineated and systematic work examining student teachers' PI unearths 29 empirical studies that, while reporting findings that centre around: reflective activities, learning communities, context and prior experiences also highlight that most of the examined work fails to describe negative findings and challenges of work within student teachers and their PI formations. While Izadinia (2013) acknowledge that much of the work critiqued tends to be small scale and qualitative, like my research purports to be, I would argue that my study does seek to not only highlight the enablers to the PI of GP trainers, but also, specifically, raise awareness of barriers to such formations. I suggest this is of as much, if not more, importance, in the context of where my research and recruitment and/or retention of future GP trainers might seek to be positioned.

Similarly, Cardoso et al. (2014) have also constructed a systematic review of the literature, this time centred around ‘three faces’ of identity espoused as personal, social and collective. In this work they centre on the typology of previous studies conducted leading thus to how these might relate and shape the field of PI within teaching, inclusive of future implications. Their final selection of 22 papers from an initial scoping of 121 was synthesised under a number of areas. Most prominent includes the literature that emerges from within teaching and nursing derived from an amalgam of socio-psychological fields. Their analysis goes on to suggest a strong positioning from within SI, something that I align with from within my own research. Conceptually, Cardoso et al. (2014) illuminate a multitude of facets, perhaps unsurprising given the sheer breadth of the literature that can be wielded from within this area. The implications for future PI research, however, signpost a need to search for subjective and emotional dimensions that are sited between micro and macro analysis. I would therefore purport that my study, which not only addresses a deficiency for PI formation of GP trainers in general, also remediates this identified gap from within education.

Latterly, one has seen the (re)emergence of an argument that moves instead from the strong stance of SI to that of psychoanalysis once more. Clarke et al. (2017) describing work that draws on a Lacan notion of an ego ideal, suggest that the student teachers they examine in their case, in order to learn to teach, must develop a capacity to balance and understand the competing demands of their consciences, desires, other people and reality. While their focus exists from within only six pre-service teachers in New South Wales and thus bears no resemblance to the context nor underpinning theories of my research. I do, nevertheless, seek to keep their findings in mind given that they remind me that teacher identity ‘...entails a complex and paradoxical entanglement of the social and individual, the personal and political, the rational and the emotional, the synoptic and the dynamic...’ (Clarke et al., 2017, p.118). GP trainers and their PI formation, drawing on my personal experiences, reflect much of this intricacy and so untangling the essence of this is what I seek to achieve.

This paradoxical entanglement is a theme that one could argue also emerges within the more recent work of Avidov-Ungar and Forkosh-Baruch (2018). In this research, questions centre on PI and teachers as expressed within pedagogical perceptions of innovation, as well as the activities and needs of the teachers who pursue such instruction. Utilising semi-structured interviews of teachers spread throughout eight colleges of education in Israel (n=27) analysis

suggests a number of domains and themes therein. Of these, and perhaps of more significance to my research is a component such that within the PI of the teacher who innovates, is the requirement of having the skills and competencies to manage such change. Whilst the authors centre their work around teachers and information technology, I see roots in these concepts for the GP trainer given that most trainers navigate an electronic portfolio of entries and components with their trainees, as well as signpost and utilise several technologies, clinically and educationally. Whether these emerge as barriers, enablers or neither, is of course what my research hopes to uncover.

More recently, in a thoroughly argued, longitudinal study of veteran teachers participating in a teacher residency program as mentor teachers (n=5), Chu (2019) invokes the same commentary regarding signposting we read about above. Here, the author notes via repeated semi-structured interviews adopting a narrative stance, how their participants, albeit experienced as teachers, adopted new beliefs and practises as they developed multifaceted identities in their journey to becoming mentors and teacher educators. Thus, much like I might expect of GPs who become GP trainers, there evolves over time, a multitude of components, that perhaps are unexpected in the early stages of the PI of my trainers. How these might emerge in my participants is held within the selection strategies I have adopted and describe later i.e., from the GP contemplating the initial steps in this PI journey to those GP trainers that have been experienced for several years.

Thus, concerning PI and teaching one sees the turn of the millennium commence with Gee (2000) and the notion of differing ways that identity might be viewed in alignment with teaching practises. So too at this time does Beijaard et al. (2004) evoke a stance, with the important predictor that the feelings of their teachers concerning being equipped for the teaching profession during teacher training remain essential. This is a theme that is echoed in others work throughout the decade via proto-professionals, experienced teachers and teacher-educators the same (Clarke et al., 2017; Swennen et al., 2010). Thus, we see in more current times a persistence in such thinking, alongside newer concepts articulated via innovative technologies (Avidov-Ungar and Forkosh-Baruch, 2018) and narrative journeys (Chu, 2019). All of this reminds one of the complex entanglements (Clarke et al., 2017) that surrounds the PI of the teacher, something I expect to be echoed within the analysis of my own research. Therefore, prior to explaining my own approach to address my research question, I return to summarise key literature points overall.

2.8 Summary of the literature review

As emphasised earlier, the focus of this research concerns itself with the barriers and enablers towards the PI formation of the GP as a trainer. It aims to concentrate on teacher development and professional learning by examining that which impedes or empowers the PI construction that occurs when a GP chooses to become a GP trainer.

In order to address my primary research question ‘What are the barriers and enablers that facilitate a General Practitioner *becoming* a GP trainer?’ this literature review commenced with a reminder of key informing theories that hold influence over the direction of travel of my research. Accepting the literature's expanse and highlighting theories both at the meso and grand stage of construction as described Crotty (1998), I position the important persuasion of the theories of SI within my work. This an epistemological area that remains relatively absent with respect to PI formation and in particular general practice training.

Concerning GP policy and practice, I have argued how history has lent to the shaping of the GP trainer PI from the starting place of the 1858 Medical Act through to the current arrangements of the RCGP and GMC in the UK. The evidence connecting PI and the GP trainer specifically expands more so towards the end of the first decade of the millennium (Waters and Wall, 2008; Wiener-Ogilvie et al., 2008) but explores in no great depth the more current and modern times of the GP trainer, with PI formation only an aspiration on the horizon at the time of this writing i.e., 2021. Thus, is demonstrated, one area is addressed by the research I sought to conduct.

In examining PI and medicine more broadly Becker et al. (1961) stands strong in the foothills of the evidence that has been exponentially driven by Cruess et al. (2014). Thus, rich insights continue to exist to explain the dynamic knots that entangle the ‘clinician as educator’ juxtaposed with ‘the clinician as a doctor’ (Cantillon et al., 2019; Foster and Roberts, 2016; Rees et al., 2014b). However, PI, its formation and its relationship regarding barriers and enablers for the GP trainer remain unaddressed at this time of writing. In the current era of drivers towards more GPs within the NHS (RCGP, 2015b) I would suggest that the recruitment and retainment strategies for the GP trainers required for these newer cohorts of doctors have gone unnoticed. I would hope to highlight this gap but seek to enable policymakers in their actions to remediate this but providing them with some answers to

consider. My view is that this can be best done by exploring the thoughts and feelings of GP trainers who have been actively engaged within GP trainee education to date. Thus, a process that captures both policy materials and trainer perceptions via a case study approach (Yin, 2014) might be seen as one trustworthy approach as I will continue to argue in the following chapters.

Teaching, too, reiterates such tensions be they aligned with Gee (2000) or Beijgaard et al. (2004). Cardoso et al. (2014) in their systematic review as highlighted above, remind me of the importance of SI in underpinning my work and thus why my data gathering methods seek to ensure the capture of what it means to be a GP trainer and how that is related to the social interactions these trainers might encounter in their lives. Fast forward to current times and the complex entanglements of these conflicts yet remain (Clarke et al., 2017), surrounding the PI of the teacher, doctor or perhaps both. How I seek to unravel such dimensions, I now turn to within chapter 3.

Chapter 3: Methodology and methods

3.1 Chapter outline

This chapter justifies the research approach that has been adopted. Beginning with a reminder of the underpinning philosophical stance, it proceeds to detail the methodological approach taken by arguing for the choice of specific methods utilised concerning the selection of participants, the data collection and analysis. It concludes with the ethical considerations that have influenced this research.

3.2 Philosophical stance

My stance towards my research is that the ontological position of this research is a relativist one. Thus, I accept that multiple realities exist that are experientially based and dependent for their form on people and groups (Lincoln et al., 2017), something that applies directly to my research described here. Epistemologically, this research rests on a constructionist paradigm (Rees et al., 2019; Lincoln et al., 2017).

The findings have been shaped as a result of the subjective, individual experiences of the research participants, i.e., GP trainers, together with analysis of supporting documentary policies and processes all relevant to training in a single locality. The choice of approach is henceforward to adopt a case study method (Yin, 2014) exploring a bounded system (time-limited and geographically ascribed) within one educational GP training programme in Scotland. As the investigator in this context, I position my stance as being one of a subjective, actively involved, facilitator in the research process and thus, I will be drawing on the principles of the insider researcher experience (Humphrey, 2013; Hellawell, 2006). In particular, my previous role as a GP trainer and it contributes to this study.

Chapter 2 of this thesis has seen my exploration of the underlying roots of identity theories and their relationship with frameworks that situate themselves from a personal and developmental perspective through to a social and contextual perspective. I had indicated that I view my study as aligning with the ontological premise of (structural) symbolic interactionism (SI) as defined by the Society for the Study of Symbolic Interaction (2019) such that it is about how ‘...people act toward things based on the meaning those things have

for them, and these meanings are derived from social interaction and modified through interpretation...’

Thus, in deriving what meanings may exist, within my study, I return to address the primary research question, namely the barriers and enablers towards the PI of the GP trainer. In doing so, I wish to highlight the fact that I view structural SI (Serpe and Stryker, 2011) as a means to answering this question given that it allows the researcher to examine the role of the GP trainer within the context of a real-life setting. Accordingly, the aim is to describe the current situation in which the GP trainer exists, considering in particular, the concept of the GP as ‘self’, being a conduit through which prior social organisation and structure reproduce themselves (Serpe and Stryker, 2011). Building on this, the aspiration of my research seeks to synthesise a framework or guidance for the future. One that ultimately might draw parallels with established *a priori* theory, such that the future identity of the GP trainer and its constructs, are visible to those considering this as a potential role. Also, however, ensuring that these influential elements might aid in invoking change for future policymakers concerning GP trainer training and education.

This role of the GP trainer within General Practice and society as a whole might well be perceived as that which Leeds-Hurwitz (2006) has already described as being part of the uniqueness which is an SI approach. The role is only one of many, within the clinical world that is general practice, as well as the educational domain of the GP trainee, such that it lends itself to being one ‘building block’ within the units of social organisation. In attempts to unpack what it is that might be constructed concerning any internalised expectations attached to this role, and in particular the networks of social relationships or associated reflective compatible or conflicting expectations, I turn to the specific method of the utility of the case study to achieve this. What follows suit is my argument and justifications for this approach.

3.3 The case study method

This research design rests on the premise of being a case study, as described by Yin (2014). It centres on the thoughts, feelings and experiences of a cohort of GP trainers from within one programme area of the Scottish Deanery together with regulatory and policy documents. In doing so, while Yin himself acknowledges that often his writing appears orientated towards a realist perspective, he reassures the reader that the case study can also excel in accommodating the relativist perspective (Yin, 2014). Furthermore, he reminds one that the defining feature of this approach is to ‘...gain an in-depth (and up close) examination of a “case” within its real-world context...when the boundaries between phenomenon and context may not be clearly evident.’ (Yin, 2014, p. 18). Something I purport is precisely the situation of examining the identity formation of the GP trainer within an everyday setting, one that is enmeshed in a clinical-educational milieu.

In adopting this approach by Yin (2014), I have taken consideration of alternative descriptors of case study, in particular, those as ascribed by Bassey (1999) and Stake (1995). Bassey (1999, p. 36), quoting Simon, reminds us succinctly of 'The Paradox of the Case Study' such that whilst there are advantages in the use of case study in examining the uniqueness for understanding complexity in a particular context, thus is a corresponding disadvantage in the challenge of generalising from a single case. The suggestion is to embrace such a paradox, which is in fact, the whole focus of the case study. Bassey (1999) cautions in attempts to compare and contrast directly different positions on key writers of case study given that one cannot be entirely sure if the writers of these had clear and unambiguous concepts within their minds. While I acknowledge this, what I have endeavoured to do below is to summarise, as I interpret it, key differences with respect to three predominant authors of case study that I have encountered (Yin, 2014; Bassey, 1999; Stake, 1995).

Stake (1995) articulates case study as being classified as two differing types, intrinsic and instrumental. In the former is the suggestion that the case study is centred around research in a particular situation for its own reasons, irrespective of outside concerns e.g., the educational climate of a single GP practice. In an instrumental case study research aims to elicit answers to one or more situations in order to understand an outside issue or to ‘go beyond’ the case itself e.g., the educational climates of GP training programmes within Scotland.

Bassey (1999) in comparison, groups a case study into three separate types: educational case study as theory testing or theory seeking, educational case study as storytelling and picture drawing and educational case study as being evaluative. Considering these categories I am not content that my case study fits comfortably with any of them, certainly the latter two described. I am of the opinion that my findings are more suited towards a descriptive locus rather than theory generating per se. Thus, I view Yin (2014) as better aligned with my research question.

Case study research by Yin (2014) can be broadly grouped under three main areas: a descriptive case study e.g., what is happening here? An explanatory case study i.e., how or why did something happen here? An evaluative case study that seeks to understand ongoing change or innovations that have been accomplished to date. In providing these descriptors, one should note that I have purposely omitted the concept of the 'Exploratory case study.' Yin (2012) suggests that the use of such terminology represents an outdated hierarchical model of any such description of case study. In defining 'exploratory' as being a purpose such that some initial attempts to collect data can determine if a topic is worthy of further investigation or research, this could be applied to multiple research settings be they quantitative, qualitative or a combination. Indeed, I note that both Bassey (1999) and Stake (1995) avoid the use of the same language within their own work and suggested classifications. Thus, given that Yin (2012) continues to remain influential within the literature with examples that demonstrate the utility of his method, ranging from citizens on patrol, neighbourhood organisation and newly appointed educational leaders through to transforming business firms via strategic planning and the evaluation of a community coalition. I suggest that his method positions itself appropriately to examine my research question.

Yin (2014) suggests that four types of designs for case studies can exist. Type-1 are single case holistic designs, Type-2 are single-case (embedded) designs, Type-3 exist as multiple-case (holistic) designs with Type-4 being a multiple-case (embedded) design. In addressing this research, I purport that my research rests with the Type-2 category. In doing so, the intention is to examine the case of one educational programme within Scotland. There are two embedded units of analysis existing such that one is a dissection of the interviews undertaken with the GP trainers within their ascribed geographical region and the second unit

of analysis being a focus on supporting documentary policy and practice that relates to GP trainers.

Yin (2014) reminds me within his writing of ensuring the need to be rigorous with the research approach, therefore one should consider the importance of rival explanations. Indeed, in the need to consider the analytical approach, not only should one take account of possible rival explanations that might assist in robustly defending the findings uncovered, but also the underpinning theoretical propositions. These propositions, combined with working with the data, 'from the ground up' lend themselves to the case study as described by Yin (2014). Thus, one aims to construct a thick and rich account (Morse, 2015) of the findings that may have direct implications for the future. However, before this writing turns to describe methods associated with the case study in more detail, I briefly highlight alternatives to the case study that I have considered and rejected.

3.4 Alternatives to the case study method

Creswell (2013, p. 7) in his opening arguments of this book reminds me of the potentially exhaustive possibilities in choosing a research approach. He proceeds to quote a number of classifications that list methodologies totalling 18 up to 28 differing constructs or categories from varying traditions, associated with discipline perspectives ranging from anthropology to sociology and cognitive psychology to history. His own tabling of such an array, emphasises that the variety of approaches potentially conceived, are incomplete, such is their continuing development and highlights the diversity of methodologies that the researcher might wish to choose. Ultimately, he positions his book such that the choice of the five approaches he focuses on (Creswell, 2013) are derived from a reflection of his own interests coupled with those popular within science and health science literature.

In considering the stance of Creswell (2013) I am also prompted by the argument suggested by Flyvbjerg (2006) who in contrast perhaps, reminds one of reinforcing reasons for utilising a case study. In doing so, Flyvbjerg (2006) articulates and retorts five common misunderstandings about case study research that an external audience might hold. In essence, Flyvbjerg (2006) suggests that the case study approach holds utility in providing concrete, context-dependent knowledge, an ability to be central to scientific development via

generalization as supplement or alternative to other methods and usefulness in both generating and testing hypotheses. Furthermore, the latter proceeds to suggest that case study contains no greater bias toward verification of the researcher's preconceived notions than other methods of inquiry and that the good study should be read as narratives in their entirety (Flyvbjerg, 2006).

Returning to Creswell (2013), of his five chosen approaches (Case Study, Ethnographic Study, Grounded Theory Study, Phenomenological Study and Narrative Study), one might see how Flyvbjerg (2006) has reinforced how a case study might therefore hold sway in my choice of methodological approach. Indeed, as an insider-researcher I would also suggest that being mindful of my context and future audience for this research, this very much aligns with this work. However, narrative approaches are something that a GP might hold significant association with, as too would the lived experiences they travail, both personally and professionally with their patients and/or trainees. Then exploring why it is that I have chosen to discount narrative, phenomenological and ethnographic approaches amongst others beckons explanations.

Narrative Research

Creswell (2013) suggests that narrative research has a multitude of forms, utilising a variety of analytical practices given its differing roots from the social and humanities disciplines. 'Narrative' might be viewed as the phenomenon being studied e.g., the narrative of an illness, one such approach that the researcher, but also the clinician, will be very familiar with as they endeavour to let their patient 'tell their story' (Seeman and Becker, 2017). In contrast, 'narrative' might also be a method used within a study to enable the process in analysing stories told (Clandinin et al., 2017), such that one thinks 'with', rather than 'about' stories.

In considering the former, 'narrative as phenomenon', currently debate exists as to its utility within the medical education literature. Milota et al. (2019) in their systematic review examining narrative medicine as an educational tool acknowledge research that has encouraged the use of narrative-based practices in the training of health care professionals. However, ultimately, they conclude that the aims and intrinsic worth of a narrative-based approach require a more robust research framework in order to determine whether or not there is an ideological consensus underpinning this method. Thus, within a medical educator's world, in addressing my research question, one contemplates that if I were to

adopt the same, I might become drawn into arguments that exist around such an area. These are quarrels I wish to avoid at a time when I seek to provide a rigorously obtained answer to my research question. Thus, in specifically looking for answers that might aid future policy direction I am dissuaded from such a method.

Similarly, in considering ‘narrative as a method’ as much as I appreciate its potential value in illuminating insights towards this research, I am cautioned, pragmatically, by the suggestions of how it might be employed. Bruce et al. (2016) in their work outline a conceptual process that relies on a combination of longitudinal qualitative inquiry utilising an evolving circular approach to develop understandings through participants re-storying of events. This approach, also adopted by others (Mishler, 2004), highlights the deepened need for recurrences and potential re-recurrences in the accounts reported by my participants. A method I would suggest as an insider researcher, that GP trainers simply will not have the time to do. Indeed, I make no assumptions that they might even have much time to engage with an initial interview alone. Thus, whilst positioned as a possible approach to assist in answering my research question, both conceptually and pragmatically I have discounted this area of research whilst respectively noting its suggested value.

Phenomenological Research

Moving on, Creswell (2013, p. 76) continues in his work to suggest that whilst narrative methodology seeks to report the stories of experiences of participants, in a phenomenological study, there exists instead a descriptive common meaning for the participants of their ‘lived experience’ of the concept or phenomenon under focus. Likewise, Horrigan-Kelly et al. (2016) in their work explain in detail how a theoretical frame utilising Heidegger’s key phenomenological tenet such as lived experience, everyday ordinariness, *Dasein* and being in the world can help to uncover the meaning of everyday ordinary human existence. All the latter being parts of conducting interpretive phenomenological research.

Indeed, whilst it is not the purpose of this thesis to explain in detail the differences in phenomenological approaches be that of a hermeneutic style as ascribed by Van Manen (1990) or the psychological slant of Moustakas (1994), one might see how my research

question could be addressed by such an epistemological ideal. However, there exist a number of areas that concern me with respect to adopting such methods.

Firstly, whilst Moustakas (1994) suggests the idea of adopting the process of bracketing in one's approach to addressing the research question, in this setting I see added value and importance in having been a GP trainer that should and cannot be excluded within this work. Secondly, in attempting to identify the landscapes inclusive of barriers and enablers to my work, while phenomenology might allow for me to understand an individual's shared experience of 'being a trainer', importantly, for some of those no longer trainers, this might have been quite some time. Thus, the experience 'encountered' may well have a number of biases left undiscovered if I seek to examine their thoughts and feelings for an event perhaps well in the past. Thirdly, and as argued before, such an approach often reiterates the need for in-depth and multiple interviews with the same participants. The latter, again, I hold of the opinion that for GP trainers, time invested would be a significant barrier to such engagement. Thus, whilst mindful and acknowledging the value in such recounts of 'lived experiences' of becoming / being a GP trainer, it is not one that I have chosen to pursue.

Ethnographic Research

Lastly, in pursuing a research approach to my work, it might well be viewed important to critically explain why an ethnographic approach has not been attempted. Given significant work has been generated in the past through such approaches (Becker, 1961) and indeed current research seeks to continue to adopt and modernise such activities (Gordon et al., 2017) then one might well ask 'why not?'

Significant in answering this is the methodological approach that is adopted by the ethnographer. Creswell (2013, p. 90) reminds us that the ethnographer, who focuses on an entire 'culture-sharing group', does so by extended observations of the group, most often through participant observation and immersion in the day-to-day lives of the participants. Indeed, within teaching, McGregor et al. (2010) exemplify this robustly in their work with teachers and professional identity development. They manage this however due to their participants' engagement and captivation within an ascribed course, of which they lead, and with a range of materials e.g., reflective course work and media that lend themselves both to course contribution, but also analysis.

In an ideal world, this approach might whole heartedly help provide answers to my research question. However, the process is fraught with a number of challenges. Drawing specifically on my insider research knowledge I am aware that the GP trainer tends to oscillate in their role between being a clinician, trainer and others (e.g., mother, sibling, parent) such that capturing the essence of the GP trainer might prove elusive. Indeed, one could argue about how the GP trainer 'exists' or 'not' depending on the presence (or not) of the GP trainee. A proportion of the work of the GP trainer goes 'unseen' through time spent on portfolio marking within personal time or time at home. Indeed, guidance to the GP trainee, even when they, the GP trainee, are not on site in the practice, is something that can span 6 months and more. This, wrapped within the clinical contexts of the GP and patient confidentiality, makes for a hefty ethical argument and complex set of arrangements within the constraints of the NHS. Therefore, whilst in some ways ideally suited to my research question, conceptually, ethnography lends itself to more likely barriers than enablers. Additionally, the scheduling of timing to use this approach within a GP trainer's working day and my own as a part-time doctoral researcher would be challenging. Thus, whilst this could be something that lends itself to future research, one way to examine my research lies not within ethnography, but instead in adopting my chosen case study method.

3.5 Boundaries of the case study and units of analysis

In considering the questions being addressed, I have already highlighted that the primary research question under examination is 'What are the barriers and enablers that facilitate a General Practitioner *becoming* a GP trainer?' While acknowledging the suggestion by Yin (2014) that case study is adept at answering questions of the 'how' and 'why' I believe, that in fact, this question still encompasses these very elements. Ultimately, I seek to describe 'how' it is that a GP 'becomes' a GP trainer. In doing so, I aspire to derive the 'why' of this, aiming that themes will be generated as one explores those concepts that assist or impede the GP in their progression towards this possible identity (Baxter and Jack, 2008).

In choosing to use the case study as my primary method, Yin (2014) reminds me that there are five essential components within the design to consider: the questions, its propositions, the units of analysis, the logic linking the data to the propositions and the criteria for

interpreting the findings. Thus, I will examine each of these in turn and outline how they are addressed in my research, as well as relating to the case boundaries and participants selected.

Regarding the propositions of my research, the essence of this research is in describing how a GP *becomes* a GP trainer such that one might ultimately determine how to ensure prospective planning and supply for the future of the GP workforce. Earlier writing has already highlighted the course of the Royal College of General Practitioners (2015a) in attempting to reverse the increasing impact of recruitment and workload, along with the associated relationship on patient care. One point in the RCGP argument are the plans to increase the numbers of the GP workforce, as too is governmental policy (NHS Scotland, 2018). Inevitably, additional trainees can only be met by a sustained or continued GP trainer workforce to provide such a service, thus is the crux of this research.

I have already outlined that the units of analysis of this case rest within constructing a Type-2 array of one singular context, that of the Scottish Deanery, drawing on one educational GP training programme as the case. To place this in context NHS Scotland consists of 14 territorial health boards, and seven special health boards (one of which is NHS Education for Scotland (NES)) together with five Scottish medical schools (GMC, 2018a). The two embedded units of analysis, namely: participant (GP trainer) interviews and documentary sources are linked to the propositions set out by the embodiment of the GP trainer's experiences past, present and future. In respect of documentary evidence, I expect to draw from local and national informing policies, GP trainer website materials and other supporting records linked with GP training.

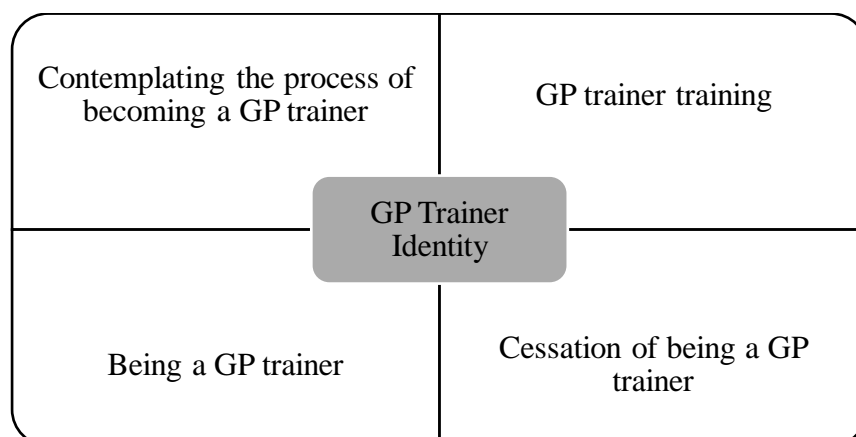
In choosing the units of analysis, I am vigilant of utilising the terminology of who or what has been selected with respects to a 'sample'. Yin (2014, p. 44) cautions against the use of such terminology in order to avoid the '...spectre of statistical generalisation...' However, I am mindful of the need to provide an argument for the selection of the data sources that have been utilised within this case (Henry, 2009). Thus, I draw on the concept as explained by Creswell (2013) in terms of employing a participant recruitment of GP trainers such that I aim to account for maximum variation concerning the GP trainer identity process. In this way, as indicated by my participant selection below, I hope to identify individuals that might vary from each other such that I can elucidate high quality, detailed interviews that might

have uniqueness, yet ultimately contribute towards shared themes that might assist in answers to my research question (Patton, 2002).

Participant selection

In considering participants, reasoning was taken of the timeline processes that might account for a GP who commits to becoming or being a GP trainer. In doing this, there is, therefore, the suggestion that a GP starts the process with contemplation about being a GP trainer, commits to GP trainer training, becomes and continues to be a GP trainer and at some point, in any of these processes, can stop being a GP Trainer. Thus, a GP who belonged to any of the four categories as summarised in Figure 1 below and having practised medicine within the programme area of the Scottish Deanery selected, would be eligible for inclusion within my research. By virtue, a GP not within these categories or providing medical services out with the programme area would be excluded. Geographically the programme area in question spans a region approximately 35 miles in radius from its central point. It includes both urban and rural GP populations (NHS in Scotland Remote and Rural Steering Group, 2008) as well as coastal and inland locations. I have not expanded on the programme area in more detail as to do so, combined with my participant details seen later, might result in transgressing the anonymity of my participants. This has been of particular importance with respect to attributes such as the minority ethnic status of the local trainer population which, aligned with age and gender, in common with national demographics, would make some of my participants readily identifiable (National Records of Scotland, 2018).

Figure 1: Participant selection



In reality, some of the participants were drawn from the cohort of GP trainers that provide current training for the specific area programme (NES, 2016) during the period January 2018 - December 2018. Additionally, there were two other cohorts of trainers that exist within this region. Doctors who have stopped being a GP trainer, i.e., those who have left the trainer programme by 31st December 2017, e.g., retirement, changed practices, left training for other reasons, and those who are in the process of attending the relevant training courses to become a trainer but are not yet registered as one. The current GP trainer's training course in Scotland is known as the Scottish Prospective Educational Supervisors Course (SPESC) (NES, 2018c). Invitations to become involved in this research were also sent to these groups.

Participant recruitment

Participants were invited via an e-mail and publicity leaflet that was sent on my behalf, by the local programme administrative team (refer to Appendix 3, p. 213) who agreed to act as an intermediary. The same publicity information (refer to Appendix 3, p. 213) was also disseminated at several GP meetings and conferences within the programme area where it was known that GP trainers regularly attend, more often for the purposes of continuing professional development. Respondents to the invitation were followed up with a telephone call or e-mail to arrange the interview at a time and place convenient to them. A reminder e-mail of the agreed meeting was also sent 24 hours in advance.

By virtue of medical and GP training, GP trainers were from multiple gender groups, mixed ethnicity and typically >30 years of age. Their demographic data was collected as part of the pre-interview information seen in Appendix 4, p. 214, followed up by use of the semi-structured interview guide (refer to Appendix 5, p. 215). It was envisaged that three to four participants would be required from each group of: those planning to be a trainer, early trainer careers, experienced trainers (i.e., normally defined as having worked for five years or more as a GP trainer) and those who have left training, to reach a level of theoretical data saturation (Varpio et al., 2017; Guest et al., 2006), namely 10-15 participants potentially. The rationale underpinning this was the aim for an authentic and rigorous description of the case (Turner, 2010).

However, in recruiting the participants, whilst I hoped to interview a number of participants that exemplified the spectrum of the PI of the GP trainer considering both the range of their

age, gender and ethnicity, I was mindful of being aware of the limitations implied by those who may volunteer for this process. Also, most importantly perhaps, their level of trainer experience to date in line with that as described by Dreyfus (2004) and Wenger (1998), i.e. the novice to expert, was an influencing factor but again, was determined by the level of engagement with this particular research. Ultimately 16 participants elected to fully engage with this research, their key characteristics as determined by the pre-interview information seen in Appendix 4, p. 214.

Finally, concerning the participants, I have utilised the process of member checking. I elected to apply the method of analysing and synthesising the data prior to sharing the findings with participants who chose to engage with this process to ensure that the initial analyses represented accurate interpretations of the data (Varpio et al., 2017; Birt et al., 2016) but being dually mindful of my participant's time in reviewing such details.

Documentary sources

Regarding the second set of unitary analysis, documentary evidence was chosen bearing in mind in several salient factors (Morse, 2015). Firstly, in considering the nature of documents as a whole, I have drawn on suggested forms of data as described by Creswell (2013) who lists a compendium of sources that fall under this category. These categories are reinforced by Bowen (2009) who reminds one that documents can be defined as a whole set of items such as: advertisements, agendas, attendance registers, minutes of meetings, background papers, organisational or institutional reports and various public records to name but a few. Thus, in determining relevant documents, I have already drawn on and continue to bear in mind the informing literature and policy that is relevant to this area of research. Additionally, however, I utilised source documents and data that were specific to the Educational Programme or the Scottish Deanery as supplied by them and available from origins such as organisational memos, reminders, alerts and relevant websites being always circumspect with regards to their origins.

Having considered the origins of the data sources, one must also consider how much of these sources will suffice in supporting the research being addressed. Malterud et al. (2016) prompt that the prevailing concept of sample size in qualitative studies is 'saturation' albeit they argue that this term is more closely aligned with the specific methodology of Grounded Theory (Charmaz, 2006) and thus inconsistently applied in the literature. Instead, Malterud

et al. (2016) argue for the concept of 'information power' by providing sufficient clarity with the research concerning the study aims, sample specificity, the quality of dialogue obtained, and the analysis strategy applied. I would argue that I have sought to provide this level of detail and elaborate further on this below. However, I do ascribe to the constructs espoused by Varpio et al. (2017) with respect to the criticality of the methodological principles that have been applied to provide rigour to my study.

3.6 Semi-structured interview guide

In considering the construction of the semi-structured interview guide for the participants (refer to Appendix 5, p. 215) I have taken account of the recommendations by Kallio et al. (2016) who adopted a rigorous systematic methodological review to develop a framework for a qualitative semi-structured interview guide. Thus, I have been mindful of the landscape already addressed by the supporting literature as well as the principles positioned from an SI approach that I have articulated above.

In doing so, I have therefore attempted to integrate the individual and societal elements that are interlaced within the concept of the GP trainer identity bearing in mind that concerning the nature of PI formation and the GP trainer there exist gaps (Cruess et al., 2019; Waters and Wall, 2008). Additionally, I have tried to be reflexive of the position my own biography plays on such an interview construct and as described by Broom et al. (2009). Thus, I have been conscious of keeping this in reign by additional 'balances and checks' that I have described in further below via ethical frameworks, data analysis and the trustworthiness approaches applied to my study.

The semi-structured interviews, as well as being aligned with the literature specific to education and PI, in order to address the research question, have also been framed taking account recommendations from recent General Medical Council (2018d) policy that seeks to utilise more focus on the adaptation of human factors. In this work, they allude that such an application of factors would allow for the promotion of effective and safe practice via an understanding of the culture of human behaviour in context, a priority for future medical curriculum outcomes. These constructs have thus assisted in framing the interview guide

bearing in mind gaps in the literature that I have previously outlined above and in the literature review that require addressing.

Consideration had also been given in this unit of analysis to the use of a focus group method as opposed to the one-to-one interviews that have been performed. Barbour (2005) reminds one that such an approach provides a safe space for participants to share experiences within medical education research whilst diluting power imbalances that might occur between the interviewer and the interviewee. Whilst appreciative of such an approach, I have discounted this for a number of reasons. Firstly, in terms of pragmatic logistics I suspect that finding the appropriate time to bring together a cluster of GP trainer individuals would be highly challenging. Secondly, drawing on previous insider experiences (Hellowell, 2006) I have encountered this approach once when a researcher attended my local GP trainers' group, something that after the event many trainers complained about. Mainly as it took away time from normal trainer meeting experiences. Lastly, bearing in mind prior research that has already been explained in chapter 2 such as Piercy and Dale (2002) or Waters and Wall (2008), then this might appear to replicate such an approach, thus lending itself to risks of being less original in nature with respect to my findings. Therefore, one to one interviews were selected.

Following initial construction of the interview guide, as a member of a GP academic department, I had access to a number of colleagues in order for the content and structure to be checked for sense prior to ethics applications and the initial study (a pilot study to test out the research design I proposed for my main study as per 3.7 below) with the participants. Thus, my writing moves to establish how my consideration of ethical frameworks informed this study.

3.7 Ethical considerations

A number of predominant frameworks have been considered when conducting this work. More specifically, ethical guidelines on research as suggested by the British Educational Research Association (2018) and the GMC (2013a) as well as the 'Duties of a Doctor' as outlined by the GMC (2014). Within the former, I am mindful of the overarching principles

and guidelines that exist, and I am drawn strongly in particular to the premise that the researcher,

‘...should contribute to the community spirit of critical analysis and constructive criticism that generates improvement in practice and enhancement of knowledge...’
(BERA, 2018: p. 29).

Within the latter is the importance of the fact that concerning interviews, if information was revealed that might pose a risk to patients or colleagues, then the participant would be made aware of the potential to disclose this information to the relevant parties required. This said, throughout the entirety of my research I am aware of the discussion centred around Shaw (2008) whose work reinforces the fact that ethics should not be ‘...largely initial business sorted and settled in the early phases of the research...’ (Shaw, 2008: p. 401) but instead, something that I should, of course, be mindful of throughout the entire research and indeed this was identified in one instance, within the initial study interviews, as described above.

To ensure my safety, I carried photographic identification and consideration was taken into account of lone policy worker requirements (The Open University, 2017a). Completed paper versions of Appendix 4, p. 214, were collected along with audio recordings. All paperwork and portable media i.e., digital recorders were securely transported and stored within a locked cabinet to which only I have access. Computer files containing personal data are password protected with any personal data kept on any portable media being encrypted. All data will be destroyed ten years after the thesis is completed (Open Research Data Taskforce, 2017).

Consent

I ensured that as well as my contact details being explicit, there existed an alternative set of details for an independent researcher. I had made it clear that participants were under no form of pressure to engage in my study and indeed given my position as an insider researcher (Kirpitchenko and Voloder, 2014; Richards and Emslie, 2000) I had a need to be mindful of my disclosure at the beginning that I have had a previous career as a GP trainer but now have no formal connections with the deanery.

The participant information sheets (refer to Appendix 6, p. 217) were evident on timelines for consent and the ability to withdraw from the process at any time, up until one month after the data had been collected. They also outlined the plans for secure data storage of the interview audio recordings and the proposed timescales for destroying the material once the research was complete. Finally, was included the position concerning the use of the research data with respect to future dissemination of the findings such as publications or conference proceedings.

Reflexivity and insider research

In considering my research, Hanson (2013) reminds the researcher that the ambiguities of being an insider researcher need exploring. The same author prompts the researcher to deliberate, amongst others, the importance of the challenges and tensions of being an insider researcher concerning multiple roles, internal politics, proximity, voice and ethics. Indeed, Floyd and Arthur (2012) had already previously reinforced such ethical elements with narrative drawn from their own acts of practising, reminding one of the need to examine both the superficial and the deep ethical and moral dilemmas as one begins the research processes.

In considering the definition of the insider researcher, while being reminded of the origins of the objective investigator (Kanuha, 2000) I am drawn to Macbeth (2001) who eloquently articulates that the analyst needs to,

‘...take up the knots of place and biography and to deconstruct the dualities of power and antipower, hegemony and resistance... to reveal and describe how our representations of the world and those who live there are indeed positionally organised...’ Macbeth (2001, p. 38)

Thus, even from the beginnings of this research, as ethically construed by Floyd and Arthur (2012), I have been mindful of the need to consider my positions. Indeed, moving further within the process, once encountering the participants, I have to respect that which Richards and Emslie (2000) describe as the need to reflect upon my own identities such that I am mindful of the reciprocity that the researcher, the participants and the setting might have on each other. I have endeavoured to develop this awareness via a reflexive interview as already

described above. So too, at the stage of transcription, does Witcher (2010) suggest that in the quest for rigour within the work, plans should be given to regional dialects and terminology of choice. Moreover, within the latter, I am mindful of the utility of having been a GP trainer and the terminological nuances that come within this clinical, educational world.

Thus, bearing all this in mind, I feel it is vital to be clear from the outset, both with myself, but also my participants and future readers of any disseminated findings, my own positionality and subjectivity. This being that I am both a medical educator and GP, cis-male, from a Northern Irish background, white Caucasian, of mixed religious backgrounds, gay, who has previously trained as, and been, a GP trainer. Throughout my time on this specific research, I have completed a reflexive diary (please see Appendix 7, p. 219) to help me collate my thoughts and feelings. In doing so, I have constructed the log entries using a reflective framework as suggested by Gibbs (1988) predominantly as this is a form that I have used on a regularly for continuing professional development within medicine. While I have considered other reflective frameworks such as Kolb (1984) and Johns (1994) in this context I am wary of them being either too simple or complex respectively, in the context of the conversations that may occur.

Pragmatically, Richards and Emslie (2000) remind me of the need to have clarity on my position prior to commencing any interview in particular. I am of the opinion that I held no sway regarding the recruitment of the participants, given that this has been done by a gate keeper as described above. The only influence being possible recognition, on some part, by participants who may know my name. On the occasions where I did know the interviewees personally due to other parallel routes e.g. being an undergraduate on the same medical degree or a GP trainer from my previous trainer's group, I have been careful at the outset of these conversations to acknowledge these elements. I highlighted that whilst we know each other via previous experiences, in the setting of this interview I would be aiming to maintain a neutral and safe position from which to allow the interviewee to answer the questions as they saw best.

Kirpitchenko and Voloder (2014) remind us of the challenges the researcher encounters, be they insider or outsider in terms of temporarily and precariously being positioned within a continuum of experiences within the research arena. Indeed, Finlay (2002) reinforces this

position, but aids also in how one can negotiate the swampy lowlands of research practice by acknowledging the criticality that is espoused through these reflective processes. I would hopefully endeavour to mirror this within my study to provide a clear, unadulterated account, as much as possible. Much of this is aided by ensuring that there are in place, entrustable processes as I chart this area of interest. This is discussed in further sections below e.g., the ethical dilemma posed by an interview interruption during the initial study.

Ethical approval

An ethics approval application was submitted to The Open University via the Human Research Ethics Committee (HREC) (The Open University, 2017b). A favourable opinion was granted with use of the reference HREC/2721/McConville to applied in future correspondence and upon final completion of the research.

3.8 The initial study and data collection

The initial study proceeded with the first interview being carried out in late January 2018. Three participants completed interviews lasting between 34 – 61 minutes. One of the primary challenges was aligning clinician/researcher availability within the working day, to suit work/life balance and commitments for the participants. Initial participants appeared engaged and relaxed in their environments that they had chosen for their interview. All elected to use their consultation rooms within their GP practice as it suited their schedules but also allowed them familiarity with their space.

It was noteworthy, that on reflection, the interview was constructed primarily with the current GP trainer in mind. Thus, some of the questions have had to be adapted to adjust for those that were at the early stages of their GP trainer training career, e.g. ‘How important is your role as a GP trainer? Does it enhance or detract from your role as a GP?’ would be adjusted to ‘How important will be your role as a GP trainer? Might it enhance or detract from your role as a GP?’

Participants appeared comfortable with the maximally indicated time of 60 minutes. Two of the GPs had planned afternoon surgeries and/or house calls to attend but were aware of this

potential timing from the outset and did not appear rushed nor hurried by the conversations. Most had insights they wished to share, or views on the GP trainer process, such that I needed to be mindful that this will have been a self-selected audience that wishes to contribute. Therefore, this must be borne in mind with respect to limitations to of this research. However, data analysis triangulation via the second unit of documentary analysis sought to supplement thematic findings as they are generated from the interviews (Braun and Clarke, 2020), thus adding breadth and thoroughness to my study.

One initial interview did raise an ethical dilemma which led to adjustments of my narrative within the introductions to subsequent interviews in each setting. In this particular case, during the latter part of an interview, there was an interruption by a ringing telephone. The GP participant elected to ignore the telephone call saying it 'was not important' and complete the interview. Reflexively, I was mindful, however, of the impact this might have created if there could have been an issue of clinical importance that needed addressing. Thus, in all subsequent interviews, I was careful to remind the participants that in the event of any unplanned interruptions during the interviews, clinical needs took precedence over any research dialogue. Otherwise, no adjustments were required in the content or style of future interviews. Therefore, in line with an argument posited by Leon et al. (2011), while it is rare, the responses and activities of the interviews were such that I have not needed to adjust the interviews at all nor return to the University's ethics committee to seek further approval for adjustments in my approach.

Participant interviews for my main study were conducted on a face-to-face basis from February 2018 building on the initial study. The interviews retained the aim to take no longer than 60 minutes maximally and where continued to be conducted in a setting convenient for the participant, i.e., their home, workplace or another location such as a local university meeting room. There were at a date and time that was mutually agreed. The setting was chosen such that its aim was to provide minimal inconvenience to the participant as well as enabling to talk openly, given they were more likely to be comfortable in an environment known to them. This is particularly important given the potential of a power relationship (Sundberg et al., 2017; Richards and Emslie, 2000) that may have been perceived by the participants. Albeit that I also attempted to minimise this with respect to my utilisation of communication approaches drawn from my own multiple identities as researcher, trainer and

clinician. These techniques were derived from good ethical practices as a researcher which I endeavoured to follow and are elaborated in further detail below.

3.9 Data analysis

Taking into consideration the learning and explanations derived from the initial study above, I have also included this data, within the analytical processes, to contribute towards the main findings. Thus, I, therefore, move to describe the approach taken towards the data analysis.

Interview audio data was listened to and transcribed, verbatim, such that it included indicators of pauses, utterances and background noises, inclusive of regular, time-stamped intervals. These transcriptions were collated with policy and documentary materials using the electronic tool NVivo (QSR International Pty Ltd, 2017).

Following the path of many researchers, my approach to the data analysis has been iterative in nature. Data were scrutinised using an inductive style of thematic analysis applying a six-step method as outlined by Braun and Clarke (2012) and summarised in Appendix 8, p. 222. This was a systematic process driven by the data content aligned with researcher identified categories. I began with audio listening and re-listening to note down initial ideas. Appendix 9, p. 223, illustrates early coding indicators utilising a word cloud interrogation that can be employed by NVivo (QSR International Pty Ltd, 2017). Building on this signposting from the word cloud and bearing in mind my research question and predominant literature indicators this allowed me to generate a more complete list of initial core codes which have been summarised in Appendix 10, p. 224. Coding involved the repeated careful analysis of the transcripts and documents, looking for similarities and contradictions to create themes which were mapped out, reworked and revised (Braun and Clarke, 2012).

In considering documentary analysis more specifically, Bowen (2009) reminds us that this form of scrutiny might be considered to be particularly applicable to qualitative case studies, which aligns with my research design. Indeed, this is reinforced by Yin (2014) who suggests that documentation can be viewed as one of six major sources of evidence. Bowen (2009) also proceeds to outline a thematic approach that is not dissimilar with my research. Thus, in exactly the same as described above, I have also applied the six-step method of Braun and

Clark (2012) to all of the documentary sources that have been collected as this second unit of analysis.

NVivo (QSR International Pty Ltd, 2017) allows for the construct of an audit trail within its software which I have utilised as the search and review of themes progressed, Appendix 11, p. 232 provides an example of this in progression. A reflexive journal (see Appendix 7, p. 219) has been maintained throughout to aid in the charting of the developments of conceptualisations and links, thus aiming to imply that the reasoning was grounded in data and informed by sensitising concepts. Additionally, I sought to enhance my own position by undergoing the same semi-structured interview that I utilised with my participants in order to be appreciative of the nature of the questioning being undertaken and to enhance my personal reflections of my PI as a previous GP trainer (Gibbs, 1988). This was conducted by an experienced qualitative interviewer who has previously undergone their own Educational Doctorate. Braun and Clarke (2012) suggest that such an approach allows for the ability to span three main continua along which qualitative research approaches can be located. One, the inductive versus deductive or theory-driven data coding and analysis. Two, a critical emphasis in contrast to an experiential approach to the data and three, the constructionist versus the essentialist perspective to my study.

In considering the analytical approach being determined, I have discounted alternatives such as grounded theory (Charmaz, 2004), narrative analysis (Clandinin et al., 2017) or discourse analysis (Frost and Regehr, 2013). This has been primarily based on significant prior exposure to the topic matter, contradictions in a narrative approach and inexperience in the use of linguistics within literature respectively. These arguments have also been articulated previously within this research.

While being mindful of participant involvement and time, concerning face to face interviews a decision was made to continue to question until there was the certainty that a notable level of data saturation had been achieved (Pope et al., 2000; Varpio et al., 2017;) I am aware of the continued discourse around this theoretical concept of the saturation threshold in its own right (Nowell et al., 2017; Bowen, 2008; Guest et al., 2006) but maintain that within my research, saturation was considered at the point within which two consecutive interviews yielded either no new themes or at the most, a new one which was predominantly idiosyncratic in nature.

A degree of data analysis triangulation was employed by using both participant interviews and documentary analysis, supplemented by member checking (n=8) and researcher reflexivity (Varpio et al., 2017). Birt et al (2016) remind us that member checking can be approached in a number of ways e.g., from returning transcribed, verbatim transcripts to allow for checking of factual information or the utility in a member checking focus group to discuss the theoretical findings. I am mindful, however, of points raised by Koelsch (2013) who suggest that researchers should not expect participant subjectivities to remain inert throughout the research process. Indeed, it is important to consider the effects of the research process on the participants themselves and how participants might be changed by their participation. This said, and whilst participation was wholly encouraged, I am always mindful of the time and efforts that my participants may have to put in towards research that I ultimately own.

Thus, in my research I have opted to use a synthesised data approach (Birt, 2016) whereby participants were provided with a summary of the main themes and subthemes and asked to comment on issues regarding if they felt these findings matched their own experiences, should anything be changed and should anything be added, respectively. In this way I hoped that participants who elected to engage in this process would enhance the credibility of my findings or highlight an area that might be construed as erroneous or absent in nature.

It is worth noting that participant's feedback reinforced the findings presented below i.e., they had no other suggestions with respect to additions, deletions or adjustments to the findings presented to them. As a researcher I was mindful they might have wished to add further commentary having had time to reflect after the interview. Feedback only provided commentaries such as the findings were representative of being familiar with their memories of training or that I shouldn't change anything. Thus, this was an analytical process driven by the data content. Chapter 4 focuses on the reporting of my findings.

Chapter 4: Findings

I have structured my findings around themes emerging from the data, relating them to the original research question posed in terms of barriers and enablers towards the PI of the GP trainer. This chapter includes findings obtained from the content inquiry of reflections expressed by the participants, corroborated by documentary analysis that contribute to my main research question. I have used illustrative responses for each theme identified.

4.1 Data collection details

Participant interviews were conducted on a one-to-one basis from January - December 2018 building on the initial study. Interviews ranged from 34 mins (shortest) to 62 minutes (longest), totalling 695 minutes (11.5 hours). They consisted of 16 participant interviews (see Table 2) combined with documentary sources totalling 79 in number (see Appendix 12, p. 233).

By the nature of GP training, all the participants were aged 34 years or more, the youngest being 34 years and the oldest 80 years of age. The mean age for the cohort was 50.5 years, bearing in mind this includes a cohort of GP trainers who have retired. There were 10 male GPs and 6 female GPs mainly from a white, British / Scottish background. All of the trainers held an MRCGP qualification with 7 participants also holding a 'Fellow of the Royal College of General Practitioner (FRCGP)' status. One participant was considering GP trainer training from within a non-training practice, 1 had just completed the SPESC course and 2 had been acting as a GP trainer for less than 5 years. The majority (n=12) had been acting as a GP trainer for 5 years or more. 10 of the GPs had commenced their trainer training at an already established GP training practice.

The documentary sources were drawn from a series of websites and organisations and comprised policy documents (locally and nationally), legislation, updates and reports from the local deanery (see Appendix 12, p. 233). Also collected were website snapshots and a set of miscellaneous other sources consisting of associated RCGP manifesto materials, RCGP communications and primary care workforce surveys and newsletters.

Table 2: Summary of participants pre-interview data

Participant	Age	Gender	Ethnicity	Holds MRCGP	Holds FRCGP	Number of Years as a Trainer	Commenced GP training at established GP trainer practice
1	57	Male	British Asian	Yes	No	>10	Yes
2	39	Male	White British	Yes	No	<5	Yes
3	34	Male	White British	Yes	No	Contemplating	Practice not a training practice
4	61	Male	White British	Yes	Yes	>10	Yes
5	34	Male	White British	Yes	No	TT*	Yes
6	43	Male	White British	Yes	Yes	>10	Yes
7	40	Female	White British	Yes	No	5-10	No [†]
8	57	Female	White Scottish	Yes	No	5-10	No [†]
9	70	Male	White British	Yes	Yes	>10	No [†]
10	51	Female	White British	Yes	Yes	>10	Yes
11	70	Male	White Scottish	Yes	Yes	>10	Yes
12	41	Male	White Scottish	Yes	No	5-10	No [†]
13	80	Male	White British	Yes	No	>10	No [†]
14	42	Female	White Scottish	Yes	Yes	5-10	Yes
15	51	Female	White British	Yes	Yes	<5	Yes
16	42	Female	White British/Irish	Yes	No	5-10	Yes

*TT=Trainer Training in progress

[†] = Indicates participant established the training practice

4.2 Themes of GP trainer identity

Figure 2 below summarises the main themes and sub-themes that have been formed from this data analysis. Examples have been provided for each of these sections and sub-sections, with the specific participant (P) extract from the face-to-face interviews numerically indicated including a marker as to whether it is the participant (P) or myself as the researcher (KM) responding. The date of the interview (date.month.year) has also been included for reference. As outlined within the methodology chapter the full list of all the initial core codes are summarised in Appendix 10, p. 224 with Appendix 9, p. 223 illustrating the early coding indicators utilising a Word Cloud (QSR International Pty Ltd, 2017) interrogation.

My findings indicate GPs can arrive at the GP trainer role through experiences and events transitioning across three predominant identities: ‘Becoming a Doctor, ‘Becoming a GP’ and ‘Becoming a GP Trainer.’ Impediment at any of these stages can act as a barrier in becoming a GP trainer. These three themes and sixteen sub-themes are also listed below:

Becoming a Doctor:

- Friends and Family
- Internal Drivers
- Secondary Education

Becoming a GP:

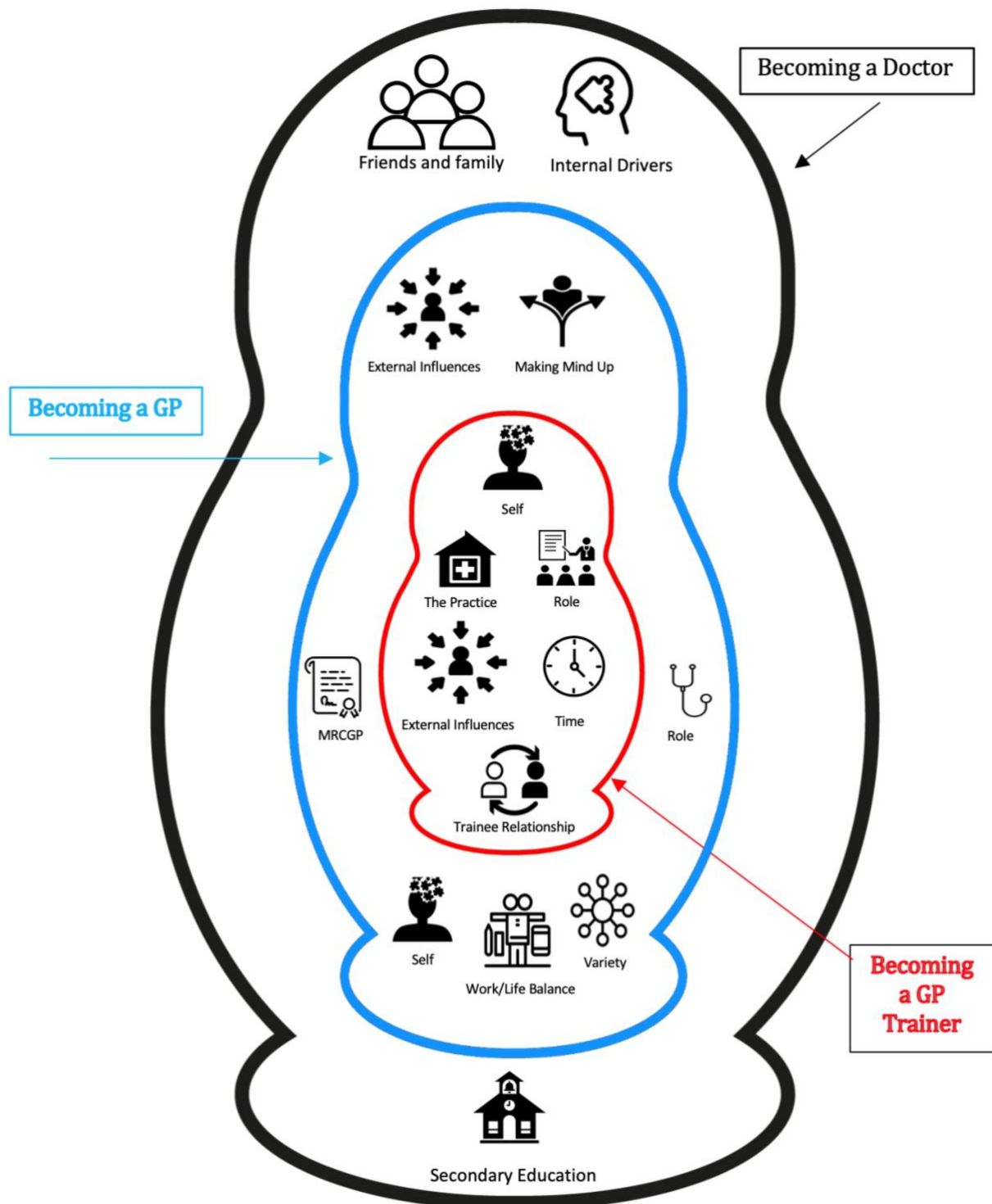
- External Influences
- Making Mind Up
- The MRCGP Exam
- The Role of the GP
- Characteristics of Self
- Variety of the GP’s Work
- Work Life Balance

Becoming a GP Trainer:

- External Influences (SPESC, the deanery, out-of-hours (OOH) GP arrangements, political influences and the GP trainer’s group).
- The GP Practice
- Characteristics of the GP trainer (self)
- Time
- The relationship with the GP Trainee
- The role of the GP Trainer

Participant exemplar quotations have been primarily drawn from transcripts based on their significance to my research question and representative of what my respondents said in their interviews. By the nature of some of the participant's explanations and answers the narrative that they provided, might, at times, have been supplemented by lengthy pauses which less well demonstrate the codes and themes that were generated over time, in a salient manner. Thus, some utterances, silences and acknowledgement responses by me have been edited to enhance the flow of the reading.

Figure 2: Summary of the thematic analysis



Theme 1: Becoming a doctor

In answering questions and probes relevant to the early stages of a medical career there emerged three key sub-themes that contributed towards the professional identity development of the doctor in the first instance with respect to those who are GP trainers, namely: the influence of friends and family, internal drivers within the person themselves and the sway that secondary education had on them.

Friends and family

The majority of participants (n=14) spoke of the influences that their family members had over choosing a career in medicine initially. Several of the participants (n=5) also recollected events that were associated with the friends who similarly held influence on their career choice.

One 57-year-old male, for example, initially spoke of the influences that friends held over his attraction towards medicine:

(P1) ‘...I was influenced by my pals because I became friends with, I guess, with the people who were also in the top bands for everything. And, we just had this, enthusiasm and this, desire to, medicine...’ (11.2.18)

He then proceeded to elaborate on this further with respect to the contributions his family had towards this same aspiration:

(P1) ‘...I mean, I guess it’s the old cliché from a cultural point of view actually...from a Pakistani background, your parents have always...you know, the parents traditionally [*laughs*] say, well, try to be an engineer or a doctor or some, some kind of profession. And, being a doctor was always thought of as being one of more valuable or prestigious kinda careers...’ (11.2.18)

Likewise, a 42-year-old female highlighted a family context that contributed to her background:

(P14) ‘...At home at the time I was at school, my gran, who lived with us, was diagnosed with breast cancer...So I had a lot of trips up to the hospital with her, particular school holiday times. So got to see a bit more about it...’ (2.11.18)

However, the importance of friends, yet also family, was also recognised by her:

(P14) ‘...My best friend at school’s dad was a retired GP, and he retired late 30’s... Had to leave practice from ill health...So, I mean, obviously he still spoke about work and that side of things, and bodily functions [*laughing*], and such things...And she actually went on to do medicine as well...’ (2.11.18)

One 34-year-old male, reminisced on a very early exchange with his mother when travelling:

(P5) ‘...and it was really my mum that, it was a kind of day, I can remember the day in the back of the car when my mum said to me [*name*] you need to start to think of what you want to do and I really had no idea... granny said we once heard of this child once that once had managed to get to a private school and he managed to do really well. And it was like folklore, where we came...and so that was the reason and then my mum and dad, you know...’ (27.2.18)

An 80-year-old male, recalled his father’s influential words:

(P13) ‘...Well, [*laughs*]...well, I just...I liked people, I liked dealing with people. And...I had a choice between medicine and music. And my father gave me the immortal words that if you do medicine, you can have music as a hobby but if you do music you can’t have medicine as a hobby and, kind of, walked out the door...’ (30.7.18)

A 41-year-old who was ambivalent about their career choices at that time noted that he was swayed less by an internal drive that others had, and more by his friends:

(P12) ‘...I don’t think I was driven from a very young age, like some people seem to be...I was toying with the idea of doing some form of English, because that was my favourite subject...and then I think genuinely a few friends started talking about doing medicine, and there seemed to be a bit of a buzz about that....’ (23.7.18)

The overall feeling arising from this sub-theme was that parents were influential, albeit to varying extents, but nevertheless, often played a significant part in their offspring’s decision to become a doctor, as did some of the participant’s friends.

Internal drivers

Whilst friends and families held influence over thoughts around a career in medicine, it is important to note that there also emanated a strong sense of internal values and motivation from many of the participants (n=9). Some of these were articulated through compelling feelings, albeit they knew not where these feelings originated; something I recognised positioned within myself such that I did not pursue these musings in the interview in all interviews. In other cases, participants had reflected on possible sources or recognised how a career in medicine might address them. In one such example, when asking a 70-year-old male respondent about the primary influencing factor for them in doing medicine:

(P9) ‘...Well, I don’t know, I mean I, I just, just wanted to do it. I mean I, you know, I wanted to do it from the, like, the age of nine or ten, I just said I wanted to do it.

(KM) Okay. And if you were thinking back now, kind of any particular driver behind that do you think or not?

(P9) No, no, it's just, just it was a career...’ (3.4.18)

As seen in P14 above and in this retired GP trainer below, health encounters, directly or indirectly created some intensity into an interest or driver that might have already existed:

(P13) ‘...but, err, no, I had quite a lot to do when I was, err, with medics when I was quite young and had had a lot of ill health. And saw what they did and, yeah, I was interested in that, yeah...’ (30.7.18)

However, as illustrated by this 43-year-old, experienced GP trainer, there was an instinct towards a role that was balanced by science and compassion:

(P6) ‘...Something from, probably, early teens. I don't know how or why. I just seemed to stick on that's what I fancied doing. I always preferred the science-y type things at school... but also the human aspect as well, I think. I didn't want to be a pure scientist...’ (27.2.18)

Ultimately this sub-theme was formed by internal influences that participants recognised, but at times found challenging to articulate, albeit they saw connections with previous health care experiences in some contexts or links with both science and professional skills, attitudes and behaviours.

Secondary education

Unsurprisingly perhaps, given the point in a person's life and the academic requirements needed to enter medicine, secondary school was deemed as an important denominator for most of the participants (n=14) when it came to the choice of route to a medical career.

Notably however, was that in some cases this emerged as being a positive reinforcement and enabler to pursue this ambition, as with the following 43-year-old male:

(P3) ‘...But we had quite a good set up with the careers guidance and advice and things through the school. So, you know, they were supportive in what you wanted to do. And, I don’t know, some schools these days maybe are less so that way, you know, or don’t have a set up with that kind of thing...’ (18.2.18)

Others, such as this 43-year-old GP new to GP trainer training, echoed the same:

(P5) ‘...Um, I, my family background, what we were... We weren’t in a position that anybody in my family had ever been possibly able to do that. I was lucky enough that my mum and dad were able to somehow manage to get me to that school that afforded me the educational opportunity to be qualified enough to do that...’ (27.2.18)

While in further cases, the barrier or lack of support led to a personal pursuit of the goal, perhaps without the aid of the school directly, as with this 43-year-old male:

(P6) ‘...No, no, my school were pretty useless to be honest... I said I’m going to do medicine. She was less than encouraging....because they kinda hadn’t anyone in medicine for about five years in the school. So, it was fine, but it was me on my own. There was no one else interested...there were some excellent teachers and excellent educators. And they were, sort of, inspiration in the way they provided education and that wasn’t all of them, but it was some of them...but no, there was no push or expectation in medicine at my school...’ (27.2.18)

Similarly, this 43-year-old, female GP trainer who had keenly established their own training practice from the outset remarked:

(P7) ‘...Yes, there was a big kind of...Oxbridge... You know, there were some people that were doing the Oxbridge exams. The group that were going to medicine, the group that were going to law and the rest of you could just pedal over. *[Laughs]*. So very, very much so...

(KM) So you were able to rise above that challenge?...And do what you wanted to anyway.

(P7) Yes...I think I just... I think I'm a bit bloody-minded. I just thought nobody's going to tell me that I can't do it, you know. That's what I've always wanted to do so I'm going to give it a try and see what happens...' (23.3.18)

Thus, within this sub-theme, one might see how secondary education primarily acted as an enabler towards a career pathway in medicine, often being supportive towards the participants. In some cases, however, there existed or nonaligned stance from within the school which ironically enabled the student by perhaps reinforcing the participant's underpinning choices.

Theme 2: Becoming a GP

Seven predominant sub-themes emerged as the answers within the guide were handled in order to determine the reasoning behind why a participant moved from having made a choice to pursue a career in medicine, to what type of doctor they might ultimately become. In the majority of cases these were multi-factorial in origin, with some holding more emphasis than others, but often inextricably linked.

External influences

All the participants (n=16) articulated how their time or experiences within various hospital departments or medical specialties, including general practice itself, helped inform their opinion to pursue a career within general practice. In some instances, this was heralded by overwhelmingly positive experiences within general practice, albeit they might already be noting which type of setting, pragmatically, might suit them best.

In asking one 40-year-old within the beginning years of their trainer experiences, what made them choose to be a GP, they responded:

(P7) "...Yeah, I chose the PRHO because I wanted to be a GP and because I wanted to be in general practice as much as I could....Because I was much more comfortable in that environment...I've never enjoyed the acute side of medicine and that...'
(23.3.18)

Likewise, in this younger 34-year-old GP who was still closer to having recently qualified with their MRCP and contemplating the training processes, remarked:

(P3) '...I was all in two minds about my training practice in a sense. It was a small practice, you know...it probably helped me to know that I didn't want to work in that kind of set up although it was small...' (18.2.18)

In other cases, it was the reinforcing challenging environments of the clinical arenas that pushed the participants in the direction of general practice. One of the participants, a 43-year-old male with a wealth of training experience, was very clear on this:

(P6) ‘...So, that, like, got me thinking again. And then, the last thing in the story at that point I saw a change in my intentions to, well, maybe I’ll be a Geriatrician. And it was, eh, one day when I was working as a Junior Doctor in Ward [name], a key medical admissions ward. And there was a guy I knew from...a Senior Registrar. A very senior registrar in geriatrics who was looking absolutely broken still doing Ward [name] as part of his training. ...And this guy was, you know, wanting to be a consultant...And I said, so, if I were to become a Geriatrician like you how long do I have to do Ward [name] for. He said, oh, about ten years...I said that’s fine, I’m not, I’m off to be a GP...’ (27.2.18)

However, it wasn’t just a medical ward that elicited these feelings. Other specialities such as medicine or paediatrics also evoked emotions of ambivalence towards that environment and context:

(P12) ‘...I didn’t like surgery, I never did. Um, I don’t like standing up for long periods of time, I didn’t particularly like surgeons. Um, you know, a lot of them are lovely, some of them are my friends, but um, no, I didn’t like it. It all seemed to be a bit, uh, I don’t know, sort of, perpetuated by self and uh, there were a lot of egos involved...’ (23.7.18)

(P14) ‘...So I had exposure to children, younger people [laughing]. So wanted to work within that. In the end actually just lifestyle, making me switch over to general practice...I did 18 months of paed training which... I, I loved it I loved neonates. I probably got more emotional than perhaps I should have done...’ (27.10.18)

Therefore, within this sub-theme we see some examples of a ‘push’ out of one area of medical specialities and into general practice or a ‘pull’ towards the external environment that the generalist appeared to offer.

Making mind up

Within the external influences that were being experienced, many participants (n=12) were also undergoing an internal dialogue or thought process as they ‘made their mind up’ about choosing a career in general practice. Often, there was the acknowledgement that this was something they were being drawn to specifically. As a younger GP of the cohort of interviewees, whom would have been through a differing training programme via changes previously described regarding the MMC in the literature review, they said:

(P3) ‘...I went through the Foundation programme in, general medicine. You know, I had GP in my head but then I started to see that the generalist was becoming less of a thing anyway, um, you know, err, it was...everything was becoming a bit specialist, you know, more specialised...’ (18.2.18)

However, the same sentiments can be seen echoed from this GP who would have had training in a time prior to implementation of the MMC as below:

(P12) ‘...well medicine was what I was thinking, I think. Uh, I’m coming across as someone who never knows what I am going to do next, but I didn’t really have a burning desire to do one particular specialty. I think most people travel through it thinking that A&E is pretty cool. Uh, it might be nice to do paeds because children are all right. But um, I didn’t really have those, for A&E maybe...you get to that point where you do stand-alone jobs, to work towards doing a GP in one year. So I did Obs and Gyn and Paeds in Stirling, and then, GP after that...’ (23.7.18)

In some cases, there was also an admission that there had existed a lack of conviction in their ultimate career choice, thus ambivalence still existed.

(P1) ‘...I, er, wasn’t actually convinced, sure I wanted to do general practice at the time...’ (11.2.18)

(P10) ‘...It was probably nothing in the medical school. But it was when I went home and did a fifth-year placement, um in general practice, and I went back down to [*place name*] to do that. Um and did it in a practice in [*place name*] and it was then. Probably was the first time I actually gave it consideration. I wasn’t interested in it beforehand...’ (11.4.18)

Thus, one notes, that during the timeline of the GP trainers’ movements towards a formal career route external influences and internal debate centred around ambivalent feelings of choice continued to hold influence. Having made a definitive choice, professional examinations in their field i.e., the MRCGP might then hold sway.

The MRCGP exam

Consideration of the influences of the MRCGP spanned the divide between the GP and the GP trainer. Some of the trainers (n=9) predominantly discussed the MRCGP with respect to influences on their own identity progression while others talked about it with respect to its influences on the GP trainer / trainee dynamic.

One of the experienced GP male trainers (P6) was also locally known as an examiner for one component of the MRCGP exam and suggested:

(P6) ‘...I don't let that cloud my training too much because I don't want to, it to become a black and white thing because GP is not black and white. It's influenced beyond delivering a message, delivering a style, delivering a, sort of, a, a tip, if you like, of how to do something. How to go about doing something. So, it's maybe not teaching the trainee that to do the CSA they need to do x, y and z to pass. It's just maybe, in this scenario, these are the different ways we could do it. Look at what I do but look at what he does....’ (27.2.18)

In contrast an experienced female GP trainer retained focus on her own experiences during a component of the exam that existed then:

(P10) ‘...again not in terms of, you know, how to manage a patient but in terms of the hoops that they’ve got to jump through to fulfil them. When I did it, you know, we didn’t have to do our MRCGP and it was a choice we made and I remember sitting in the oral, and the exam was totally different, and I remember sitting in the oral exam with 37 weeks pregnant and getting nothing but antenatal questions fired at me...’
(11.4.18)

This is reinforced within policy documents which remind the trainer / trainee of similar concepts:

[*re. Policy - (RCGP, 2017)*] ‘...Being a GP - the Core Statement...The MRCGP currently has three major components. Guided by the blueprint, the areas of the curriculum that they test deliberately overlap with each other, so that your performance can be tested in a variety of ways. For example, your clinical problem-solving skills can be tested through the Applied Knowledge Test (AKT), case scenarios in Clinical Skills Assessment (CSA) and through case-based discussion in Workplace Based Assessment (WPBA)...’

So, one sees here that as a sub-theme for some trainers the importance that the MRCGP exam has a part to play in enabling the doctor to assume the PI of GP, however, there is relatively minimally mentioning of this exam with respect to the GP trainer / trainee relationship which one encounters later in these findings.

All of the participants (n=16) talked about the actual role of the GP, in some very specific cases they made a direct link with how this impacted on a person's identity. My interview with P8, a female GP who did GP training for 5-6 years before stopping, was interesting in this matter:

(P8) '...I suppose it's just your role in the practice and the team and things...obviously respect, I suppose.

(KM) Okay. What makes you say respect?

(P8) Well, respect within the team and respect for others and team working and that sort of thing. It was good... It was interesting, I was at a dance class last night and one of the girls was an OT and has retired recently. And she said the only thing she found difficult about retirement was the fact that she lost her professional identity overnight...Which she found difficult to deal with. So, I suppose that sort of... She said, you know, she'd always had that role since she was 19 or something. And I'd never thought about it before that. It's that's sort of thing, isn't it? It is a position of standing in the community, in a way, yes. And, um... I don't know. I don't know really how to put it into words..." (23.3.18)

Many of the GP trainers also spoke specifically about the influences that a precise GP had as a role model on their career choice. Often this was described within the context of an early (undergraduate) teaching setting (n=11) with many of them (n=9) naming a specific, inspiring role model. P4 a 64-year-old retired GP trainer who is still doing some out of hours GP work, remembered:

(P4) '...Yes. A-, as far as general practice, who influenced me with that was um, his name escapes me. The guy who was a prof in Edinburgh...? Um, what do you call him again? I can remember him, yes. No, before your time. You'd not know him. He was quite influential. He, he was a lec-, senior lecturer in Aberdeen.

(KM) Okay.

(P4) And I remember at that time general practice, like most times you know, had a hut you know, which was nice because it was nice and warm and friendly...'

(20.2.18)

(P1) '...but what really I think...was my biggest inspiration was actually the...who's the programme coordinator, is actually... [name] who, was up in [place name] but who ran the, the day release programme. And I found him very inspirational...'

(11.2.18)

Therefore, one sees the importance of the role of the GP as an important contribution towards the PI formation of the GP trainer, acting primarily as an enabler. This might be viewed dually, that is the role that the GP themselves enacts and experiences, but also in the role as modelled by other colleagues.

Characteristics of self

It was found that 13 of the 16 respondents articulated in some way how a characteristic of the 'self' was important in contributing to the professional identity of the GP. Honesty and trust (n=6) were mentioned on occasion, as was the concept of the need to contain an element of 'something special' (n=6) albeit they had difficulty articulating this further. A 42-two-year old female respondent introduced the idea of dual responsibility in caring:

(P15) '...Um, I realised that quite a few, a few years ago. Um, and I see myself as a support to patients, a diagnostician. Um, diagnostician, decision-maker. Um, and somebody who cares for people but also feels that people should also care for themselves as well. Um, and that I shouldn't take full responsibility for what's happening to them...I know that sometimes conflicts with some other people's beliefs but that's what I firmly...' (2.11.18)

Others, such as this well-established GP recognised an inner feeling or calling but still had challenges in expressing this:

(P1) ‘ ...For me, it’s... It was very much like a vocation, and it was that feeling about, you know, this, being a GP is something special. I don’t mean in terms of a position. But it’s special in that you have the... You should have the aura of, er, of, of somebody who is beyond, um, reproach, I think. Would that be the right term to say? So somebody who you know you... If you can’t to turn to your GP, who can you turn to?... Who can you trust?... So it has to be that level of trust, and to me, that’s what the i-, identity is...’ (11.2.18)

Ultimately, this sub-theme suggests that the GP trainer recognises a set of inherent characteristics that might contribute towards their current position. Although agreement varied on what this might be or how it can be expressed, nonetheless there was acknowledgement of these self-generated feelings that exist.

Variety of the GP’s work

The variety of a GP’s work was a sub-theme (n=7) when it came to influencing a participant to consider this profession. P5 as a GP at an earlier stage in their GP career, and having recently just completed the SPESC course, recalled:

(P5) ‘...I think I realised at medical school that actually that I didn’t want to do that single system issue that – I didn’t think it really challenges me to be honest. I mean no offence to my colleagues, I’m sure they’re very expert and very skilled. Um, you know I look at general practice and think it’s really going to be really straightforward to become a GP, it’s going to be really hard to be a good GP...’ (27.2.18)

However, a GP at a point further along in their clinical and trainer's career also called to mind:

(P6) '...Um, what's my identity? I like being a GP and there are definitely challenges but I've, I think, I'm a little being ground down by other position challenges. Um, identity, I love being a generalist, I love being able to answer questions on most things...' (27.2.18)

On some occasions the GPs would explain this by comparison to their hospital specialist colleagues. P9 as a retired 70-year-old GP who had progressed through a then 'new' form of GP training noted:

(P9) '...Because although we were new GPs, we weren't new to general practice...because we'd been training...we'd been trained, we had skills and we had knowledge skills and attitudes which were those of a general practitioner...not of a hospital doctor that had been transferred...' (3.4.18)

Thus, this sub-theme of the variation of a GP's work was not as strong as one might perhaps expect. However, this is perhaps because there was often overlapping talk that moved to connect with the concept of a GP's work/life balance as described next.

Finally, in this sub-section, nearly all of the participants (n=15) spoke specifically about how in considering a career in general practice, the knowledge and implications of achieving a healthier work/life balance held persuasion over their career choice.

In some instances, such as P3, a GP contemplating a GP trainer role, it was possible for them to compare and contrast with family members who also had a medical career:

(P3) ‘...seeing my [*name of family member who was a hospital doctor*] again who... who was still doing all these lates and nights and it didn’t really seem to ever to stop. I thought, ah, I just don’t really want that. And that probably influenced my path and I only applied as a GP I didn’t want anything else...’ (18.2.18)

In other contexts, it was the implications of the career and the effects on family members and loved ones that can be viewed as the main driver towards general practice:

(P11) ‘...And in that kind of hospital medicine, there would have been an expectation of moving around the country, um, and by that time I was engaged, and I had got married at, at the end of my first house jobs. So, there would have been family issues about moving around a lot. And general practice had the attraction that you could find a place and stay in it...’ (16.4.18)

(P14) ‘...I’m very, very close with family and it means a lot to me. And it probably means more to me than the job. So, I didn’t want to move and thought that this is not... I loved the job, but this is just not going to work out. I want to have a life as well...I don’t want to be resident on calls or consultant doing 100-hour weeks. As it is, [*laughs*] we’re doing lots of hours as a GP...’ (27.10.18)

Thus, we see in this sub-theme the predominant enabler of considering work and family life in generating movement of the doctor towards a career in general practice. This, coupled with overlapping influences derived from self-characteristics, the variety of GP work, the GP role, the MRCGP exam, ‘making one’s mind up’ and other external influences, demonstrates how there exists a heady interplay of barriers or enablers towards a GP PI. These same types of

influences also remain important as the GP gravitates towards the PI of the GP trainer. The third, main theme outlined next.

Theme 3: Becoming a GP trainer

In this final, predominant theme, six inter-linked subthemes appeared as having connections with my research question regarding the PI formation of a GP trainer. As in the prior main theme, there was a typical nature of intersecting concepts. The six themes consisted of external influences, the GP practice, characteristics of the GP trainer (self), time, the relationship with the GP trainee and the role of the GP trainer.

External influences

Within this context of external influences, five dimensions affecting the professional identity of the GP trainer were specifically reiterated: SPESC, the deanery, out-of-hours (OOH) GP arrangements, political influences and the GP trainer's group.

SPESC

Fifteen of the participants spoke about the positive influences that SPESC or previous iterations of this had on the beginnings of their journey to fulfil a personal wish to become a GP trainer.

(P6) '...But if you're in a supportive environment, if you're enthusiastic and driven, that's fine. You can do it. I think the, this SPESC course, from what I've seen of it, is pretty comprehensive....It teaches a lot of good stuff, and in terms of practicalities but also the theories as well. And I think it does shape people as doctors, individuals, as well as trainers. So, I think that's a good thing, so... But if we can get to that stage, it's a case of, are you actually interested, are you in a supportive environment?'
(27.2.18)

P16 was a GP trainer who came from a long term established training practice. When probed directly about the usefulness of SPESC she reflected:

(P16) ‘...yes, definitely. I mean I think to start with I probably felt quite daunted by the role and wondered when I was going to join the SPESC course. I really wasn’t sure what background everyone else would have come from and whether they’d all be much more experienced or older than me. Um. So I think there was that bit of uncertainty at the outset of the process...’ (21.11.18)

In some instances, the GPs would highlight that the processes involved via SPESC could appear robust or intensive, but ultimately useful in becoming a GP trainer. P2 having recently completed this course was well positioned to comment on recent experiences of the GP trainer’s course:

(P2) ‘...To be quite honest, I suppose at the start, looking at the requirements to get on SPESC and to complete it, at the start, it’s like, blimey, that’s quite a lot, and I could see why people might be, you know, fazed by that...in fact, once you get into it...you know, nothing that’s worth doing is easy...’ (12.2.18)

This was reiterated by P5 as a GP who was in the process of finalising outcomes from the course also:

(P5) ‘...so I think I started the process to become a GP trainer in August...it took me four or five months to get all the boxes ticked that I would need to tick to do it...certainly going through the final questions that I have to go through to, you know, things like how can you ensure your trainee is safely prescribing, you know. And I think the language and the attitude, and the training philosophy is complementary...’ (27.2.18)

In this manner, we see examples from recent and more experienced GPs of the utility in the SPESC course or its previous iterations in being a strong enabler towards the PI of the GP trainer.

The deanery

Regarding the participants 8 spoke about 'the deanery' although by this they meant the local programme arrangements, noting that the logistics of what has constituted the deanery have changed historically over time. Opinion appeared relatively divided with respect to how the deanery affected them with some (n=3) being more negative in their opinions, whilst others offering a balanced or more positive opinion (n=5).

P1 as a well-experienced GP trainer who had been at a training practice that had been long-term established, appears to still remark on the deanery as being less facilitative in nature:

(P1) '...I mean, I had, I did have an unsettling experience as well, which actually, made me think twice about it, in which, there was an incident with a remedial trainee. And, um, where I didn't feel supported...I felt let down by my partners at the time...And, and so that, and even, and also I have to say by the faculty as well. So, and that unsettled me as well a little bit as well. And, um, so I, yeah, so that kinda influenced a few decisions in my career...' (11.2.18)

P13 as an 80-year-old, retired GP trainer remarked, however, on the support provided by the deanery as it was in his era:

(P13) '...Um, well, the... the department of general practice was very, very, supportive and continued to take an interest, you know, obviously as well as the ...I mean, your GP training came a mixture between the department of general practice, um, them and home as it was the National Health Service and, err, primary care...' (30.7.18)

As a dimension of this sub-theme the deanery could therefore be positioned as one eternal agency that had the possibility to enable the PI of the GP trainer, but by its very nature might also detract from such a role depending on the interactions that might occur.

Out-of-hours (OOH) GP services

Several GPs were reflective of the fact that within their identity as a trainer, delivery of OOH service was an important element to take into consideration. Seven GPs spoke about this at varying times in the interviews.

P2 had some unique insights as a GP recently qualified who is aware of OOH services as they currently stand and link with GP training, juxtaposed with coming from a family background where he could observe previous generational experiences of OOH and GP training then:

(P2) ‘...Well, as I said, the old days, when, when you would have been a, you know, like, a GP trainee in [*place name*] ...You used to know when they were... When my [*family member who was a GP*] was on call because the GP trainee came to the house for tea and stuff at the start and they would come into the practice and all that, and then, um, you know, they, they would have to have a flat in the town because you couldn’t commute, um, you know, when you were on call, um, and, you know, going from... You know, you would have gone from, from that sort of thing to by the end of your GP trainee year, you know, being on call, with cover, but, you know, being responsible for that, that area for the whole weekend, kind of thing. And so that... You know, that’s a completely different, you know, environment from where we are now, I think...’ (12.2.18)

Likewise, P9 as a more recently retired GP, was able to contrast changes with a GP contract that influenced the context of OOH arrangements and the relationship of training when explored further:

(P9) Well things about out-of-hours are important. It's the same thing and I think one of the things that we... That although we were tickled pink when out-of-hours disappeared in 2004, was it 2004?

(KM) Yes.

(P9) I think what we realised later was that we'd lost something enormous...’ (3.4.18)

As a dimension, OOH was therefore considered by some GPs as an important influencing factor, whether it was wholly an enabler, or a barrier appeared to provide ambivalence with this cohort of trainers that highlighted its influence. Policy was perhaps clearer in this manner.

Political influences

Throughout the time periods recounted by the trainers only 3 of the trainers alluded to political influences directly. However, multiple documentary (n>20) sources pointed towards the influences of policy and practice that underpinned the transformations of the PI of the clinicians. P2 has had recent experiences of implementation of a newer version of the GP contract as well as MMC changes within his own training:

(P2) ‘...You know, I think that with the GP contract, you know, that’s, that’s changed the environment hugely, and I can see also, then, um, you know, moving away from the, kind of, green card system, um, and moving more into the, sort of, MMC system, and yeah, no, I, I can see that that’s... There’s been huge changes...’ (12.2.18)

Policy, by its nature is much more explicit at times in terms of the position it seeks to influence:

[*re. Policy - General Medical Council (2012)*] ‘...The new arrangements build on the existing procedures by which we approve the GP trainers of GP registrars...’

[*re. Policy – Training Practice Accreditation Application*] ‘...GP Training Practices must meet the statutory requirements of the General Medical Services Contract (GMS contract). To ensure that you are aware of the breadth and detail of the standards GP Training Practices have to meet, we would ask you to complete the declaration below. I have read, understood and agree to act in accordance with the: GMC Standards for Specialty Training, RCGP Standards for GP training, NES Training Practice Agreement, NES Doctors in Difficulty Policy, European Working Time Directive 2009...’

It would therefore seem that when considering the PI formation of the GP training policy would not directly emerge on the GPs minds as an important enabler as such. However, given that policy underpins the process that trainers embark on and adhere too, it resides in the background as an important, scaffolding, external influence amongst others.

The GP trainers' group

Finally, in this section on external influences, many (n=10) of the trainers spoke of the usefulness of the GP trainer's group in contributing towards their identity. P11 is noted to have 14 years of GP trainer experience at the time of the interview and thus would have many encounters with the GP trainer's group:

(P11) '...the other thing talking about trainers' courses was there's a very active [place name] trainer's workshop and all the trainers in [place name] met regularly...' (30.4.18)

P14, who is noted to place the value of her own family as important in earlier conversations, also views the GP trainer's group to a similar extent:

(P14) '...Um, I suppose it's not just about how you appear to the trainee, and what the trainee thinks of you. There's also that whole training family, that training cohort across the areas; so the people that you meet at conferences...' (27.10.18)

Likewise, P16 who is also known to be from a strong academic background remarks:

(P16) '...I think also through the process of having peer reviews and feedback from other training partners and also colleagues within the trainer's group as well. You start to realise that actually, you know you are quite competent at doing this and you do have something to offer to, not just to trainees but to colleagues as well. So I think that was an important, sort of, development over that time...' (21.11.18)

Thus, the GP trainer's group emerges as a positive enabler within this sub-theme of external influences. Coalescing with stimuli drawn from political influences, OOH, the deanery and SPESC I note that this sub-theme competes with others towards the GP trainer PI.

All of the participants (n=16) spoke of their relationship with their GP practice. They primarily spoke about this positively, highlighting the role of the GP trainer and what this meant for the practice. Having recently retired but still working within OOH, P4 notes:

(P4) ‘...as I say we were trainees. Uh we’ve got another trainee who’s, [*trainer’s name*], you know [*trainer’s name*] trainees who stayed on in the practice now. So another thing was obviously we were looking for people you know retirement, and yet another trainee has just asked, and another trainee went in, so we’ve taken on all, both of our trainees...’ (20.2.18)

In contrast P5 as being more newly qualified and a recent GP partner thought:

(P5) ‘...But I’d seen how enriching it was. I’d seen how it was helpful for the business model, I’d seen how it was helpful for the, you know, recruitment, I saw it was benefit... Enriching for capacity and how it was enriching financially. There was lots of benefits to the practice, massively enriching for the whole education and the ethos and the practice culture. So it was influential, yes, and I can’t envisage a practice without trainees you know...’ (27.2.18)

Likewise, P12 reinforces this sub-theme as a GP who could be said to stand positioned half-way between the experiences of P4 and P5:

(P12) ‘...so it’s the practices, that’s what GP to me means. It means that we are getting new people from time to time. From the point of view of, kind of a recruitment crisis in general practice, it makes a massive difference. I mean, we have got two locums working just now who are both previous registrars. If we didn’t have them, we would be in real trouble I think. So it makes a big difference from that point of view...’ (23.7.18)

However, some participants (n=9) did comment that were mindful about how well their work might not have been recognised within the practice environment.

P1 had latterly stopped being a GP trainer as he had moved practices:

(P1) ‘...I-, well, I don’t know whether that, it’s real or perceived or my own perception. My own perception was that it was a skive that, you know, not seeing patients directly, ...Um, and that guilt, that sense of guilt that, you know, my, when you see your colleagues working very, very hard, seeing patients, and you’re sitting down reflecting, it just... You know, it’s a, you know, difficult...’ (11.2.18)

Likewise, P6 whom works within a busy urban, training practice:

(P6) ...I think there's a perception out there that, and there's a bit of reality actually, you know yourself, it is all hard work to get there...and there's some, sort of, sacrifice in terms of time and effort and... but, also, in terms of the workplace-based assessment and the amount of that that we have to do...and some practices don't have the ethos of education. They say they think they might, but they don't...’ (27.2.18)

P14 was also similarly clear that within her GP training practice, the environment that the practice portrayed was important:

(P14) ‘...But I think the, the reason that perhaps there aren’t the amount of trainers that there could be, isn’t because people don’t want that role, or want that identity; it’s because they’re looking at how that will impact on what they’re already doing with a busy job....’ (27.10.18)

Overall, there was, thus, a very clear enabler of the GP practice as being important in contributing towards the PI of the GP trainer, as long as the practice environment was one that sought to support that embodiment of the GP trainer that was construed between the GPs seeking out this role and the environment within which they worked.

Characteristics of the GP trainer (self)

This third sub-theme focuses on that which is the ‘self’ of the GP trainer. All of the participants articulated the concept of the GP trainer via characteristics or attributes that one might possess or expect to possess. Interestingly, throughout the conversations, a large number of the cohort (n=11) were understated in their progression towards their medical career or their GP trainer persona. They often (n=8) spoke about the added value or enrichment that the identity brought to their lives, even from the first interview this was an area GP trainers expressed as exemplified by P1:

(P1) ‘...yeah, I guess, um, my identity as GP trainer I, I think originally I was worried that I probably wasn’t clever enough, and so I... When I realised that it wasn’t about the actual, knowledge as such, it was more about the patient empowerment, I think I-, it changed that, yeah, that understanding...’ (11.2.18)

This appeared to be reaffirmed irrespective of the gender of the participant as P7 echoed:

(P7) ‘...Always being a kind of a middle-of-the-road student and not... You know, I wasn’t in top classes or anything. I was just kind of a borderline, okay student. And not that anybody ever told me that I couldn’t do it, but, you know, a career’s guidance had one stage has said that maybe I should look at geography and become a weather girl...’ (23.3.18)

However, what appeared clear was that there was an important characteristic of educational care or development that these participants exuded:

(P5) ‘...yes, it’s hard to predict, I mean I – you know I’m very fortunate, I’ve got another GP trainer in the practice who has been doing GP training for a very long time, you know, I think I rest on his experience where, you know, he just feels it’s been a massively enriching experience for both him and for the practice. So I guess I rest upon that hope that I have that same experience and same – and I’m sure I will...’ (27.2.18)

Likewise, the educational nurturing of the GP trainer appeared under the surface of the conversation as noted in interviewing P14:

(P14) ‘...Ach, I learn a lot from it, to be honest. It's a really good way of keeping up to date. But also, there's something really satisfying about trainees coming in, being not sure about what they're doing, and actually seeing them blossom, and become competent, and seeing that progression...’ (27.10.18)

But also, as in the case of P7, as a mother of four children:

(P7) ...it's somebody that, you know, you feel a responsibility for them. And, you know, it is like, you know, having your own child that you want them to do well. You have aspirations for them, you know...’ (23.3.18)

Thus, in this sub-theme I note the emergence of a core characteristic that appears to enable the GP to become the GP trainer. Understated in nature, yet apparent when probed, there is attention from the GP trainer towards educational attainment, within themselves and without. Some things, however, do get in the way.

Time

Perhaps unsurprising given the current climate of the NHS and GP workload. Time was cited as a significant barrier in performing the role of the GP trainer by all of the participants (n=16). As the first participant P1 generated a code that remained constant throughout:

(P1) ‘...think recognising that it is hard work, and how you do that, I don't know... And, so yes, it's hard work. And also, then valuing that hard work...somehow almost, I guess, if you could have a condition of becoming a trainer or a training practice, is that you should ensure that there is dedicated time for the trainer...’ (11.2.18)

Despite being an experienced GP and GP trainer with a well-established and supportive practice environment it would appear that even in the context of a trainer such as P6, time provided challenges:

(P6) ‘...the training and the follow-up and some practices don't have the ethos of education. They say they, they think they might, but they don't. They don't realise that it's actually... There's a time resource on the support on all that are involved...’ (27.2.18)

In some cases, time proved to be the main and significant barrier to meaning that a GP trainer ultimately had to give up their PI as a trainer, as in the case of P8:

(P8) ‘...Yeah, the workload just was... Just became... I was already struggling to deal with the tutorial side of it. [GP partner name] used to do one tutorial a month. [A different GP partner name] did none...And one tutorial a month so it was two a week, at least. Plus, obviously, extra supervision and things wasn't really a significant bit....And I possibly could have dropped a bit and had a bit more protected time, which I didn't have. But I didn't want to do that...Because I thought, well, there's patients needed me to consult and I was torn two ways...’ (23.3.18)

It was very clear throughout all the interviews that time impeded the PI of the trainer. As P8 exemplifies above there was a dilemma between enacting the time required of the PI of the clinician versus that of the GP trainer. The contributions of the relationship between the trainer and the trainee were, therefore, also important.

The relationship with the GP trainee

All of the participants spoke about the importance in the relationship that was established between themselves and their GP trainee. PI remarked from the outset:

(P1) ‘...I quite like the apprenticeship model. I think appro-, apprenticeship model works, and I think, you know, certainly, in general practice, the only way’ (11.2.18)

Whilst still contemplative regarding assuming the role of the GP trainer, P3 also appeared to recognise a similar relationship:

(P3) ...it's really no different to an apprenticeship really is it, you know. I mean, that's I... I see that you're going to learn from somebody who's been working in that role for... for a while. And it's not so much about the... the academic part of it it's more about the... the workings of people...I mean, actually I do know of one situation where a trainer was feeling quite disillusioned in the way... because their trainee kept failing their exams no matter what they were doing. And, err, you know, I think he felt like he was in some way not doing things right. I mean, these people are all clever they've all got to where they are, you know, they've all done exams what's the obstacle here...' (18.2.18)

As alluded to by P3 above, comparisons were also made between the 'good' trainee and the 'doctor in difficulty' with many of the trainers (n=12) noting that the latter cohort had the potential to be a significant barrier in its own right.

(P4) '...And then I got, I actually got some very good trainees...Uh one of the things about training is that um a lot of people do it because they get very good trainees and that's why they continue...' (20.2.18)

Within this relationship the need to 'look after' or 'nurture' the trainee (n=15) was a foremost factor in their minds with some (n=8) drawing on the developing process of the trainee via the metaphor of an apprenticeship model (n=8). P5 demanded criticality as he outlined:

(P5) '...so I look at being a GP trainer, um, I guess there's two parts, so, um, a little bit like within the practice I bring a certain type of perspective of a GP to the trainees within the practice. And, you know, when trainees come in they'll ask me a question, you know, very much I'm not a give out the answer, type of thing, and I'll say well do you know the evidence, what's the evidence behind it. Teaching them to demand evidence, think critically. And that's my role in the practice, you know, and we each have a different, slightly different way that we answer questions or we help support the trainees...' (27.2.18)

Likewise, P6 recognised the need to know when to nurture or supportively challenge:

(P6) ‘...Most of them quite like that and I sit and follow it. Um, so no, I don’t think, I don’t see it as a hindrance at all. I love the feeling of nurturing someone through from virtually... Not nothing, they’re not, they don’t come with nothing. But, you know, rabbit in the headlights of being in a GP training to confidence at the end of it...’ (27.2.18)

Ultimately, however, all the trainers wished to highlight that primarily the relationship they had with their GP trainees was one of the main reasons that enabled them to assume their PI of the trainer. A role that they recognised as separate from others constructed within the community.

The role of the GP trainer.

Lastly, interlinked with the apprenticeship model but specific to the GP trainer identity is the concept of the trainer undertaking a specific role (often that of the GP as a clinician) and modelling it for their trainees (n=11). However, an important element of this was their very specific role in terms of being a teacher, which they all (n=16) discussed. P1 was aware of the need to exemplify this behaviour:

(P1) ‘I think again the GP trainer the, is using that understanding of yourself as a GP and role modelling that for the trainee but helping them nurture that and that sense of identity, I think, as much as anything else...’ (11.2.18)

Much more succinctly P2 commented:

(P2) ‘...my [name] was, was a... Was the trainer in their practice, and so again I was aware of that role....’ (12.2.18)

P3 was more articulate in comparing and contrasting that there existed these two roles, the clinician and the teacher:

(P3) ‘...they’re pretty similar, um, I’d like to think that there’s more of an emphasis on actually just trying to demonstrate doing your job to someone else so they can learn. You know, rather than being two separate entities, you know, being a trainer and being a GP I would like to think that they’re not that dissimilar...’ (18.2.18)

P4 developed this further by taking the concept of the teacher and reminding me of its connections with the origins of ‘doctor’ terminology:

(P4) ‘...I always felt that, and I always said this to everybody I come across, trainees and students, that being a doctor meant, meant being a teacher you know, because that's what's the whole idea. You know it's an academic thing...’ (20.2.18)

Reflecting back on many years of experience, P13 was able to see these connections with role modelling and teaching as he had encountered and enacted throughout his career:

(P13) ‘...I think they have to have this interest in actual teaching or sharing information and sharing the sort of ethos...I think there is no use just, um, I don’t think they’d be allowed to be trainers if they weren’t,...didn’t have that...Had to be interested in education...’ (30.7.18)

Therefore, this final sub-theme regarding being a GP trainer is situated around role-modelling both that of the clinician but also, importantly how to be a teacher. This appears primarily to be an enabler towards the PI of the GP trainer.

In summary these findings draw predominantly on the sources of 16 participant interviews from a range of GP trainers, over a number of decades, along with supporting policy documentation. Whilst the latter has been wealthy with respect to what I would have hoped to be reinforcing evidence of how policy and practice might scaffold PI formation (see Appendix 12, p. 221), ultimately it has not been notably informing to my research question. I highlight this further in writing below. The voice of the participants, however, has been, in my opinion, much more instrumental in contributing towards the substance of GP trainer PI formation. Three predominant themes: ‘Becoming a Doctor,’ ‘Becoming a GP’ and ‘Becoming a GP trainer’ have been generated. These appear to exist as embedded structures within the PI of the GP trainer. In considering the latter theme in particular I note several

sub-themes that contribute towards becoming a GP trainer that assist in addressing my research question: external influences, the GP practice, characteristics of the GP trainer (self), time, the relationship with the GP trainee and the role of the GP trainer. The impact and deeper significance of these findings are discussed in the next chapter.

Chapter 5: Discussion

As a reminder, the primary aim of this research was to address the question concerning the barriers and enablers that facilitate the PI formation of a GP in *becoming* a GP trainer. Three predominant themes: 'Becoming a Doctor,' 'Becoming a GP' and 'Becoming a GP trainer' have emerged that enable a response to be construed. I will argue that all three contribute towards an embedded structure of PI formation, that can exist, from person to person, within the interactions that symbolise the GP trainer (Serpe and Stryker, 2011).

The latter theme, in particular, holds several overlapping components that influence the GP trainer and could be seen as most contemporaneously relevant in communicating to a broader academic audience what these might influence as being key within future policy and practice. Perhaps, befitting of an approach that has been guided from within a symbolic interactionist position it has been challenging to position some of these themes and sub-themes directly into a positivist domain of being an absolute barrier or enabler. Rather, as aligned within the constructionist lens that Rees et al. (2019) denotes, the facilitating power that selected components direct towards the GP trainer's PI are derived from the meaning and interpretations that can be attributed to them. However, before addressing these in detail, it is salient nonetheless to consider what has 'gone before' with respect to the persona of the GP who contemplates becoming a GP trainer. Thus, I will begin by highlighting some critical linkages as I see them, that serve to scaffold the GP trainer in place via the identities of one whom 'becomes a doctor' and then onwards to 'becoming a GP.'

5.1 Being a doctor

Friends and family

I have already noted here that enmeshed within the sphere of influences on the student contemplating entering a career in medicine are those emanating from friends and family, internal drivers of the person and secondary education. In considering friends and family, this is a sub-theme which can be assigned to the influence that people have towards primarily enabling the PI of being a doctor. Given that approximately three-quarters of the student population entering Higher Education will be aged 20 and under (Higher Education Statistics Agency, 2019) this perhaps comes as unsurprising. Whilst centred on undergraduates, rather than pre-university entry per se, we see this illustrated within dramaturgical analysis by

Vries-Erich et al. (2016). These authors illuminate how medical students (n=19) recount their emotional stories as a component of PI. Especially notable is that these stories are shared, both within the safe space of professional settings or mentor groups, but also via a 'backstage arena' utilised by the students regarding non-medical friends and family. Thus, perhaps highlighting the important positionality of friends and family in contributing to medical PI formation. This is reflective within my findings where the participants have recurrently acknowledged the contributions of both groupings of people towards decisions made to apply for, and enter medical school, as have appeared via Vries-Erich et al. (2016). Carrying these onwards as mechanisms of support and influence within undergraduate life, professionalism and PI being one element therein.

The example provided by P14 on p. 87 on her grandmother's illness, for example, also highlights the influence of family in enabling this professional life. Whilst purely reflective writing in nature, Bobrowski and Bobrowski (2020) recount similar experiences today as they begin their medical training. Thus, once more, past or present, we see the importance of friends and family within this social exchange that is entered in the pursuit of a medical career.

Earlier studies (Hilton and Slotnick, 2005; Rees, 2005) locate the concept of professionalism as emanating from within a socially implied contract. Hilton and Slotnick (2005) offer a perspective constructed on the 'proto-professional,' i.e., one whom undergoes a lengthy period of learning by developing knowledge, skills and experience in order to become a fully-fledged professional. The latter author's perspectives weave a route around psychosocial development a la Eriksonian style, combined with reflective practices and an acknowledgement of 'peripheral participation' working towards the centre (Lave and Wenger, 1991). Ultimately, Hilton and Slotnick (2005) conclude that curricula provide opportunities to grow and mature skills that allow the medical student to acquire and maintain a sense of professionalism, with adverse environmental conditions contributing through the effects of the hidden curriculum.

However, Rees (2005) proffers caution in her commentary to the latter work, reminding us that the Hilton and Slotnick (2005) snapshot on the proto-professional does not yet provide a complete picture on exploring the development of professionalism across the medical continuum. Concerning my research, P13's father's influence on p. 87 as an example, might

suggest that there would appear to exist within my participants a reminder that even before medical school entry, there exists already a dimension of influencers that have the potential to evoke or support change in the neophytical doctor.

Internal drivers

It is interesting to note that in recent research by Wass et al. (2017) concerning the factors influencing policy, whilst there are clear and articulate recommendations that focus on the student experience prior to medical school entry, the attention emanates from within secondary school interactions rather than family or friends positioning, as for example P12 on p. 88. Wass et al. (2017) were based on a robust literature review, combined with several national task force style workshops. Perhaps thus driven by an element of pragmatism as to what can be influenced and achieved in the social arena, it is somewhat surprising that direct consideration of influencing friends and family is omitted. However, I would acknowledge that their work focuses directly on what medical schools can and should do to encourage students to consider a career, not only within medicine but within General Practice more specifically. Thus, I would suggest that at this point in a student's professional journey, even the concept of the GP trainer is perhaps too much to be made aware about. Albeit being mindful that it is often the very same trainers who might be the individuals being asked to role model and encourage (Harris et al., 2019).

Role modelling and encouraging the internal drivers of the student is something that Yardley et al. (2020) remind us about. In their multi-phased, ethnographic study (n=32) they explore the realities of transitions from the anticipated to the actual life experiences, of the medical student being a doctor, i.e., the concept of 'first-time' events required of a newly qualified doctor. What they suggest is that students can feel a change in self-confidence and proficiency as they transition from the settings of rehearsing diverse skill sets into the reality of practice. Within my participants, whilst they do not always articulate this so well or indeed can talk about what their drivers necessarily were at that point in their lives, e.g., P6, p. 89, one notes a recurring theme that permeates throughout all three arenas of 'becoming,' centred around the self-perspective of the individual. Perhaps, in the earlier stages of becoming a doctor, this is less well-articulated, but as my writing will continue to show, this is amplified over years of experience.

This experiential learning and affirmation of internal drivers that might be considered predominantly enablers towards PI formation from within, is something that is reinforced by the research described by van den Broek et al. (2020). Their work, centred on the transitions of final year medical students (n=21) from one medical school in the Netherlands, also explores PI transitions from student to practitioner. In their case was a specific focus on themes associated with social identification within a professional group, such that emerged concepts of prominence for the group (cognitive centrality), perceptions of suitability and links with the group (in-group ties) and perhaps of most importance to my research, the positivity of emotions associated with the group (in-group affect). The authors note that students' experiences enhanced purpose and pride as their work becomes more central to their patients' care. I observe the same, echoed within my participants in the concepts they articulate regarding obtaining a 'human aspect,' like P6 on p. 89. However, again, one must err caution in extrapolating ideas articulated by GP trainers about medical school entry days, albeit these serve to scaffold the crucial core of 'Being a GP Trainer' which comes later.

Secondary education

Thus, in considering medical school days or even entry to it, one must give some credence to the influence held by secondary education over such matters. School, as an environmental sub-question, has the potential to be seen as a positive enabler towards PI formation within medicine. Returning to Wass et al. (2017, p.7) this time there are apparent and specific recommendations regarding the need to "Develop, promote and disseminate positive, realistic awareness and understanding of general practice to pupils in primary and secondary education..." In my research, we see this, certainly historically, as an exciting narrative that is divided. It was clear that some participants e.g., P3 and P5 on p. 90 experienced input and encouragement in their consideration of admission to medical school via secondary school support. In other contexts, such as P6 and P7, p. 90, it was very much left to the individual to pursue their goal, indeed at times even ignoring the advice proffered by schools to seek an alternative career, a successful student trajectory achieved, nonetheless.

My prior research in this area (Muir et al., 2017; Muir et al., 2015) would perhaps allude to the fact that the earlier and more interactive are the interventions within primary or secondary

school settings, then already is there hope of an enhanced awareness of the route that needs traversing to becoming a doctor, or even a GP, but not a GP trainer specifically, at that young age. Anecdotally (Copeland and Muir, 2015), but expressed in no great depth, I am aware that schools to date can often fluctuate and vary in their ability to direct students towards a career pathway in medicine. Indeed, we see this reflected in research derived from secondary school literature also (Aschbacher et al., 2010) where results underscore the need for interventions from socialisers accustomed to the relevant world of practice (science, engineering or in my case General Practice), to encourage students to be aware of such possible career choices and routes.

One might take parallel gleanings from teacher PI previously articulated (Vähäsantanen et al., 2008) at this point. If we acknowledge, as do these authors, that learning and development can be inhibited by the organisation (or the individual who develops separately from them), then helping to orientate the organisation to enable and empower them, might be seen of much more value. Whilst bearing this in mind I would caution, that at this point in a student's career, it would seem unfair to address the particular role of the GP trainer per se. However, I do think there are opportunities for this to be at least involved within the explanatory language that might occur in interactions of these cohorts of students, e.g., "Welcome to this session today...I am both a GP and GP trainer..." In the move, however, from 'being a doctor' to 'being a GP' more specifically, it would be invaluable to amplify a strategic approach to ensuring recruitment to the GP cause, and perhaps GP trainers after that. Indeed, perhaps in the early processes of engaging in becoming a GP trainer via induction courses such as SPESC articulated below, there is provides an opportunity for the GPs to self-reflect on the personal identities they retain and how these might have born influence on their current roles and ambitions to date. Thus, in becoming a GP, this writing turns to explain this more deeply.

5.2 Being a GP

I have demonstrated that within this area, seven predominant sub-themes emerged when determining the reasoning behind a participant moving from choices made to pursue a career in medicine, to what type of doctor they might ultimately become. Many of the participants highlighted that their influencing elements were multi-factorial in origin, with some holding more emphasis than others concerning being a barrier or an enabler, but often inextricably linked.

External influences

It was clear from all of my participants regarding the importance of experiential learning when it came to enabling decisions about a career trajectory into general practice, e.g., P6 and P12, p. 93. I have already highlighted how policy has long since recognised the need for a clear and formally identified pathway into this specialty that has its origins from within law itself (Simon, 2009; Parliament (UK), 1976). Indeed, most recently there has been a directive from Scottish Parliament (Gillies, 2019) that amongst its 10 key recommendations suggests that there should be a system in place to increase teaching in primary care, as well as develop and grow the GP educator workforce to enhance capacity.

Looking back at one of the previous iterations of changes to junior doctor training requirements via the MMC (Department of Health, 2003) there was espoused the ideals that there would be scope for those who have yet to make a firm choice (of career) to undergo a variety of experiences which would enhance core skills. Indeed, P2 as a new GP trainer, p. 106, clearly recalls such influences. Amongst these was the belief that this would allow for training time in a GP setting. Although logistically this has proven slightly more challenging than first thought, it does bear indicators of value and utility (Walzman et al., 2008), bearing in mind that the authors of the latter work utilised a small evaluative questionnaire with their cohort (n=35). Remaining within undergraduate experiences we see this now clearly articulated through work which has been carried out in more recent years to allow students additional time within a GP context applying the concept of longitudinally based programmes (Bartlett et al., 2019; Holden et al., 2015). Whilst being mindful that these studies are often case studies or commentaries conducted within a single centre, the depth and rigour of their

approaches suggest a very transferable argument into the wider arena, with many medical schools following suit (Imperial College London, 2020; University of Glasgow, 2020).

This longitudinal approach is also something that I have already highlighted as being mirrored within the work of PI formation (Monrouxe, 2010, 2009). Thus, one can see linkages between both the embedded experiences that affect the career considerations of the medical students or doctor in training and how these contribute to preconceived ideologies that Monrouxe (2010, 2009) alludes to. In a similar vein, by applying a robust mixed methodological approach, Monrouxe et al. (2014) also remind us of the important contribution of negative experiences towards a future PI. This can be likened to my participants, who spoke of situations whereby they recognised that the environment in which they were training did not suit them e.g., P7 a female GP who established her own training practice, p. 92. Additionally, Monrouxe et al. (2014) highlights how professional dilemmas, which includes student abuse, result in an emotional residue, something that perhaps re-emerges and impacts on career decisions. Reflexively and retrospectively, I recognise from my own experiences and echoed in a small number of my participants (n=6) that having undergone, e.g., surgical training for some time, both that environment and the training route that was woven within surgical examinations, was not one I wished to tread, P12 as an experienced, middle-aged GP who established his own training practice, p. 93, also reiterates this point.

Likewise, within education more broadly, we are reminded Timoštšuk and Ugaste (2010) had noted a similar theme from within their research with teachers in training as discussed earlier. Here they suggest that amongst external influences that are prominent, include the importance of the student teachers feeling belonging towards a teaching community with the experiences that their participants encounter providing meaning to them, albeit they do not talk about teacher assessment processes per se. Thus, one can note how the importance of external influences can have an impact on the PI of the future teacher or GP. This said, the route to becoming a GP now, but not always in the past, still treads a formal assessment process which could have included the award of the MRCGP.

Membership of the Royal College of GPs (MRCGP) has had several iterations (Murray, 2008; Elfes, 2007; Walker, 1990) before the current format that exists today. Thus, it would be foreseeable given the age range of my cohort that the MRCGP was mentioned from differing positions, most likely as an enabler, albeit contributing in a similar way to the PI of the GP and subsequently the GP trainer. My findings (see P6, p. 100) disagrees with Pitts et al. (2005) who reported the MRCGP as being a possible barrier for their trainers in that having to hold the MRCGP was an ideal requirement as part of the GP trainer processes. The aspiring GP trainer today will view this as less of a problem given changes in policy and GP qualifications that have emerged over the last 10-15 years since this work was done. All GPs now must hold the MRCGP as part of becoming a fully qualified GP, and hence this matter is likely to disappear (RCGP, 2019a).

This said it is highly likely that the experience of the attainment of the MRCGP both by the trainer, and the processes by which the trainee now undergoes such a qualification, will remain a point of discussion. Regarding the latter, it was clear that in the past the status of holding the MRCGP was viewed by my participants as something that provided an enhanced sense of respect and perhaps status as one interviewee, a 70-year-old male recalled in Chapter 4, p. 95:

(P9) ...we'd been trained, we had skills and we had knowledge and attitudes which were those of a general practitioner, not of a hospital doctor that had been transferred and therefore because we were, [*laughs*], you know what I mean, like crème de la crème. You know? We were the top. It, it was sort of expected of us by everybody, that we would be the, the trainers of the future...' (3.4.18)

However, as reminded by Lyon-Maris and Scallan (2013) one can no longer consider the MRCGP as an indicator of merit, nor debatable as a route to the harmonisation of a trainer requirement. The MRCGP is now an indicator of holding a GP licence, as such, other markers of excellence regarding the GP trainer must be seen to emerge (Lyon-Maris and Scallan, 2013). This said, it is notable that all my participants do hold the MRCGP via the various iterations on offer, but not all of them (n=7), however, hold a Fellow of the Royal

College of General Practitioners status (FRCGP). Indeed, important as an absence within the findings, aside from the concept of the MRCGP itself, there is minimal mentioning of the college or RCGP at all. Whilst the criteria for FRCGP are distinct (Royal College of General Practitioners, 2019c) from attaining the MRCGP and have been applied to the GP under very different conditions and settings, perhaps this is something to be mindful of for the future. I am not, therefore, suggesting that FRCGP should be seen as a route to becoming a GP trainer, but the opposite, i.e., those who hold a GP trainer status may well be eligible to apply for and obtain the FRCGP given the work and efforts that have gone into attaining a GP trainer role. This might open up future avenues to highlight a differing role for the RCGP in their interactions with GP trainers.

Remaining with being a GP however, the MRCGP, therefore, has an additional construct that is worthy of note. This is concerning the discussions that will occur as the GP trainee is supported by their trainer in obtaining their own MRCGP. Whilst some of this is discussed later with respect to the GP trainer / trainee relationship, it is interesting to note the work by Spooner et al. (2019). The latter authors sought to undertake a set of qualitative interviews within doctors in their final year of GP training or within five years of completion of GP training (n=63). Findings synthesised from a combination of one-to-one interviews and focus groups suggest that the doctors reported that their training had prepared them to deal confidently with most aspects of routine clinical GP work but left them feeling less ready for additional responsibilities of managing a practice or appreciating wider NHS organisational structures. Perhaps, there is a sense that there has been a focus on the day-to-day knowledge and skills of the GP (i.e., those needed to pass the MRCGP), but less attention on the broader context in which they work. Such is the bind conceivably for the GP trainer, i.e., the need to help prepare the trainee GP for assessment via the MRCGP, yet in doing so, other sacrifices are made. This said, P15, an experienced GP trainer and multi-tasking mother, p. 98, demonstrates that this wider thinking can still emerge as a career trajectory progresses.

Spooner et al. (2019) remind one that there are spaces in knowledge which impede GP trainees or those newly qualified moving towards positions of responsibility with pressures to meet assessment requirements (e.g., MRCGP) meaning other topics of interest are given less focus. Of these, one might be the GP as an educator, in practice or the expanded arena. Being mindful of this concept might, therefore, be given credence. However, there are numerous factors at play as the medical trainee undergoes their training journey, one of these

being the concept of making their mind up about which training pathway to tread. An issue that this writing now moves to address.

Making mind up

Earlier writing has made comment on personal and developmental perspectives of identity. Kroger and Marcia (2011) have made remarks on the concept of 'The Identity Statuses' such that whilst I have already committed to an underpinning theoretical basis that is evolved of SI, it would be naïve to ignore the language that is utilised from within psychosocial developmental identify frameworks (Erikson, 1950). By this, I mean the concepts that are related to the individual who forms an identity by first undergoing an element of exploration, then commitment (or not) to a role in life. In this, it would be true to say there can be seen clear echoes of the memories my participants speak of concerning 'making their mind up' when it came to choosing the career of a GP.

It was rare, indeed, none, of my participants spoke directly about knowing they wished to enter a career as a GP immediately e.g., P10, a long-established GP trainer whose career initially commenced within a medical training scheme, p. 95. All spoke of dilemmas and persuasions that added to a balance in their minds of the route they might take. Chellappah and Garnham (2014), albeit a questionnaire-based inquiry centred on one London medical school, reflect such findings. In their work, they note that only 13% of their students ranked GP as their first-choice career despite them having a positive attitude towards the subject, although why this was the case was not a focus of their work. Interestingly this same figure, differing with respect to the context of what is delivered within an undergraduate curriculum, i.e., 13% of undergraduate medical education training being within primary care, is also the subject of Newbronner et al. (2017). These authors explored the impact and perceived value of this delivered education across two UK medical school sites. In a mixed-methods approach in which they acknowledge their limitations regarding power (n=129 surveys; n=42 interviews/focus groups) they do highlight the importance of primary care in the development of 'apprentice doctors', those seeking to be a GP or otherwise.

If we accept, in those potentially seeking to be a GP, as per my participants, that there, therefore, exists this element of cognitive dissonance when it comes to committing to a GP

career, e.g., P3, a younger GP who was also still contemplating GP trainer training, p. 94. Then drawing more directly from the roots of SI, one might see how social interactions can modify a person's interpretations (SSSI, 2019), in this case towards their PI formation. Returning then to Crossley and Vivekananda-Schmidt (2009) we can see how such reinforcing evidence can be provided. The latter authors speak of the importance in PI formation of professional and social inclusivity such that when one assumes a PI, they find themselves drawn in, ever closer to specific social contexts, with others beginning to fade. Thus, we can see that positive experiences, and affirmations of such, might well enable a medical student or trainee doctor to commit to a chosen career. In my research P10, p. 95 shows one example of how thinking changes in this vocational journey, this is exactly the type of experience that Allsopp et al. (2020) would envisage might propel the doctor towards general practice in their discussion that seeks to tackle the denigration of this speciality as a career.

Such commitment to a chosen career has been enhanced within general practice by past observations of Gillies et al. (2009) also. In their recommendations gleaned from learning journeys as they sought to 'Distil the essence of General Practice' via a tentatively soft qualitative approach, they note that people (trainees included) respond to leaders who are altruistic. Not only this, but the same authors also suggest the importance of listening to the trainees, not just about career structures or core competencies, but to hear about the discourse on core values. In doing so, they end by advocating that then was a time to retain a role within evolving and challenging times to enhance the potential for leadership. I would speculate that from within these leaders needs to be positioned a clear cohort of GP trainers, amongst others, who should have a central role in shaping and directing these conversations of importance. Of course, the GP trainer is but one role of the GP, others do exist.

Role

In my data, the roles of the GP straddled a two-pronged component when examined for answers to my research question. All of the participants highlighted the nature of the position of the GP and the multiple facets that this might invoke depending on one's own preferences, e.g., P8 as someone who ultimately ceased being a trainer remarks on this clearly on p. 97 However, for many of the participants, there was also the discussion of a

person who acted as a role model for them, by enacting out attributes of the PI they sought to achieve such as P1, p. 98. Thus, it would appear this concept of role exists as both the person and a task to undertake when it comes to enablers of PI.

Touati et al. (2019) come some way in enabling the conversation about the professional role when encountered as collaborative work across organisational boundaries. In a multiple case study approach (n=57) they draw on Giddens (1991) view of identity as a dynamic structural element of social life, to suggest that three prevailing identity roles existed within their participants, i.e., medical expert, team member and care coordinator. The former work is robustly addressed, but acknowledge this centres on family physicians in Canada, not the UK. What Touati et al. (2019) suggest is that there is a tangle of identity roles and collaborative practices enacted through the complexities of organisational and institutional features, coalescing around patient-centred care. This importance of patient centred care and relationships is also very much echoed within the qualitative research that Fairhurst and May (2006) describes regarding what GPs (n=19) find satisfying in their work. I will return to this concept again within the GP trainer / trainee relationship, however Ahluwalia et al. (2020) in their own smaller scale, UK based research (n=11) note similar findings when it comes to the concept that GP trainees have a significant effect on learning and patient care, thus reflecting an acknowledgement of a deeper relationship than a didactic trainer / trainee bond.

Role modelling has long since been explored in medical education (Hurley, 2009; Reuler and Nardone, 1994) and is likely to continue (Barnes et al., 2020). The latter research in particular, by adopting a rigorous systemic review methodology, suggests that whilst no work uniquely addresses the transition to a clinical leader per se, evidence would indicate that fledgeling graduates perceive leadership as being individualised and hierarchical. Thus, the suggestion that being prepared to undertake such duties requires time, experience, and responsibility. Therefore, one can see a similar trend perhaps with how this might emerge with potential GP trainers of the future? One of my participants, P1 with 13 years of GP trainer experience to recount, p. 114, is recognised as a local leader within the clinical communities and thus might well be viewed as such. In this, as the writing will continue to show, I see opportunities, where this might be afforded.

The same concept of the role being undertaken, or the role being modelled, is also noted within education (Androusou and Tsafos, 2018; Kempe, 2012). The former authors' research

centres on their investigations of PI within preschool teachers in Greece. Here, in their interviews (n=20) they note how their teacher PI formation was gradually enhanced through integrated processes of pre-service teacher education, vocational amalgamation and practising professional duties along with in-service training. Androusou and Tsafos (2018) speculate that teachers whose training is based on a compact perception of the PI of preschool education teachers align with the discourses that are consistent with the wider social representations of preschool teacher identity, i.e., the role modelling that they might have seen to occur or experience in the past. Within some of my participants such as P4, p. 97 this is certainly something that impacted on them such that they still recall the effects.

Likewise, Kempe (2012) who reports on newly qualified drama teachers (n=104) via a survey method, suggests that there were three main elements to their teacher's identities. Labelled as self, role (i.e., teacher) and actor, the discussions centres on consequences associated with a teaching role and its associated responsibilities (some of which are externally prescribed) such that the expectations and demands of the teacher will be partially determined by how the *self* interprets such requirements and translates them into their praxis. Thus, what one may understand here is how the teachers in this setting set out to role model their professional knowledge, skills and attitude in action. Therefore, be it Greek teachers, family physicians or GPs, we see a core component of self that is enmeshed within role modelling that is undertaken, a point I will return to later. *Self*, also, is of significance. I, therefore, elaborate on this further below.

Self

Perhaps fitting best in contributing towards the sub-research question centred on internal drivers that enabled GP PI formation, I have encompassed my participants (n=13) reflections about a variety of characteristics that they suggested when they moved to talk about themselves and their relationship towards becoming a GP as belonging to the concept of *self*. Equal numbers highlighted the importance of 'honesty or trust' e.g., whilst others simply recognised it was 'something special' but when probed further found this challenging to articulate e.g., P1, p. 99. Other authors have expressed this well, however, identity and self are steeped in historical narratives and explanations (Chen et al., 2011; Goffman, 1971) that seek to contrast theoretical reasons to enable and understand social role and identity.

Early into the arena of PI formation within medicine, Crossley and Vivekananda-Schmidt (2009) sought to construct an accurate representation via their participants of a curriculum tool that could understand features that would enable PI formation. Enlisting 496 students from one UK medical school who completed a cross-sectional survey, the authors suggested that the responses yielded a three-factor solution. They went on to outline that student doctors with more pre-programme experience (e.g., prior first degree, part-time working within health care) may have a more developed professional identity score, especially those who had more experience of task-based work. Amongst their conclusions, confidence in teaching about one's profession appeared to be a key determinant regarding student's qualifications. Within curricula, they ended by suggesting that clinical attachments cause a stepwise change in professional *self*-identity. Policy as a reminder on p. 106 actually does quite well to remind us of this importance as do my participants, e.g., P10, p. 95.

Rodgers and Scott (2008) utilised a similar three-factor theme at one point in their explanations of the development of personal self and PI in learning to teach. Describing identity as being shifting and multiple, they present identity as one that can be 'storied' from first to the third person. Here is the suggestion that identity can be presented as told by oneself about oneself (first person), stories related to oneself, about oneself, by another person (second person) or stories told about oneself by a second person to another person (third person). Thus, identity is reconstructed and reinterpreted over time. In considering my research, what I do see are glimmerings of some first-person accounts of how my participants feel they embody characteristics that might also be associated with a GP, e.g., P1, p. 99. Whilst not enough to provide compelling data saturation alone, what I do recognise is a triggering of an internal sense of emotions within what I appreciate in being a GP myself. Thus, some, but not all aspects of *self* might be mirrored within the attitudes and values that I hope I might possess as a GP.

Attitudes and values are areas that within *self*, have been explored within other health care professionals. Cope et al. (2016) made this their very title when exploring PI formation within a group of resident surgeons. In their setting, 16 surgeons and surgical trainees underwent ethnographic observations in the operating room environment. Following thematic analysis, they noted six pertaining areas regarding values and behaviours in their surgical cohort. Namely: attitudes of perfectionism, accountability and service, self-

management behaviours and personal resilience, self-critical and neurotic behaviour, effective team working and personal initiative and leadership behaviours. It seems somewhat disappointing, therefore, that from within my cohort, little has been espoused aside from honesty, trust or something special. Perhaps this articulates what makes it different to being a GP in some way to a surgeon, certainly I would not expect perfectionism to exist given that GPs in particular deal a lot of their time with managing uncertainty such that being neurotic would not be a helpful trait (Schneider et al., 2014). However, perhaps my methodology of choice has not sought to unpick such elements of the self in the way an ethnographic approach taken above has (Cope et al., 2016), thus resulting in a limitation of my work.

What then might be the characteristics of the good GP? The literature is sparse on such qualities, but one such piece of evidence (Braunack-Mayer, 2005) adopted a virtulist approach to medical ethics to explore notions of good doctoring and the assets in the work of 15 Australian GPs. Whilst light regarding full details of the methodological approach taken, the answers proffered from this research suggested that the good GP was a doctor who practised in a certain way (although this was not actually ascribed), providing accessible, comprehensive, and continuing care to patients. Not, therefore, anything that much resembles what my participants had to offer. Perhaps the answers exist instead in the fact that this could be a difficult concept for GPs to articulate? Maybe there is something regarding how the self is orientated that links with a GP's continuing care offered to patients? A not unenviable task for the 'GP to be' to address via the scales of work / life balance. Something which this writing now turns to outline.

Work/life balance

The theme of work/life balance from within my participants is unsurprising at best. It certainly aids in answering my sub-research question centred on environments and tasks that might enhance or impede the GP trainer's PI. This has been a recurring topic that one can see replicated in other parts of the literature. In the USA, Gaufberg et al. (2017) examined a cohort of Harvard graduates in an attempt to understand how the curriculum and culture of their version of a longitudinal clerkship (a concept described earlier) contributed towards learners' PI formation. Twelve graduates from this course underwent the process of a qualitative, semi-structured interview with analysis via a constant-comparative method

(Strauss and Corbin, 1990). The researchers concluded that within their participants was an emphasis on the importance of identifying and maintaining the personal identity of the student as they developed into a physician. They link their work with Monrouxe (2010, p. 44), who reminds us that "...medical students (and doctors) are people, individuals with their own personal, emotional and cultural stories which influence their professional identities..." This is something I can see replicated within the recollections of my own participants, e.g., P11, a trainer nearing 25 years' experience, p. 101.

This reproduction is echoed once more by Gyberg et al. (2019) in their aptly named research 'Being Stuck between Two Worlds - Identity Configurations of Occupational and Family Identities.' This latter writing is not directly focussed on the medical profession nor set with the UK but does look at a cohort (n=124) of young Swedish adults (mean age 33.29 years) who were interviewed about work and family priorities. The authors suggest that six different types of identity configurations might exist, from the most frequent 'Family first', followed by 'Everything is important, Struggling to prioritise, Now family comes first, Inability to prioritise, and Work first' (Gyberg et al., 2019, p. 1). Thus, is the suggestion that identity as structured through the domains of occupation and family, illustrate degrees of conflict and configurations that might have an impact on the individual. P14, p. 101 as a 42-year-old female GP trainer, mother of two and strong local connections with her immediate and extended family articulates this well.

This is something that can be seen mirrored in research that is focussed on those considering becoming GPs (Harris et al., 2019; Spooner et al., 2019). In the former, research conducted while being significantly mindful of the GP recruitment crisis that is currently being experienced, these authors set out to examine how training experiences affected their participants (n=78) continuing motivation and career intentions. They also sought to consider how newly trained GPs reflected on their training programme by preparing them for a broad range of roles and responsibilities that would be undertaken within later GP life. Their summary suggested that their work provided reinforcing evidence that authentic work experiences assist the individual in choosing a GP career. Additionally, however, was the commentary that many of the participants were troubled by current arrangements and instabilities over traditional, GP partnership arrangements with suspicions voiced that these configurations would not meet evolving political agendas and future NHS plans. We can therefore see, in similar commentary from my participants, such as P4, p. 108 how there is

some reflection via their ruminations to me, about how much impact and influence working life arrangements might have with on outside existence.

Likewise, Harrison et al. (2019) sought a similar research question within their explorations of early-career doctors (FY2), investigating influences on them as they choose which speciality to enter. In their cohort (n=24) what emerged was the stimulus of medical school, the correct 'personality' to fit the specialisation, banter and hierarchy of specialities, FY2 placement experience in general practice, GPs being criticised by other doctors and the difficulties of GP work. Within the latter in particular, the authors noted that participants had preconceptions of GP life being balanced and less stressful, the reality for some being somewhat different with challenging environments encountered. We can see from my participants such as P6 whom also has strong RCGP connections, p. 88, that the same considerations of work and life emerge within my discussions with them. Given that many of them remained within a GP career for >40 years suggests that even if there are periods of challenging work ahead, there might be potential strategies to cope with this. In either case, work / life balance forms a solid pillar of consideration for the early career doctor.

Of course, medicine does not hold a monopoly when it comes to career choices and work / life balances. Long et al. (2018) provide one such example in their in-depth analysis of 30 graduate student workers. Bearing in mind these were students (all in various stages of a PhD) with a research question focussed on work / life negotiations of parenthood, three salient identities were seen to emerge. Presented as graduating student status intersecting with gender and culture, the authors concluded that there were multiple tensions at play as their participants negotiated work / life and the meanings they gave to it. In my research, we see some of these tensions played out in tentative stories associated with life partners and children e.g., P11, p. 101. Policy also seeks to reflect and remind GP trainees of this:

‘...Anticipate and manage the factors in your work, home and wider environment that influence your day-to-day performance, including your ability to perform under pressure, and seek to minimise any adverse effects...’ (RCGP, 2019b, p. 37)

Thus, we see a well-circumscribed area that is the boundary of work / life and its hold over career aspirations and choices of the possible GP and onwards. One final area that also holds

much sway over elements of 'Becoming a GP' is the variety of the work that a GP has in day-to-day life.

Variety

Variety, whilst core to a GP's workload, emerged, although not surprisingly strongly (n=7), as a relative sub-theme of influence within my participants towards enabling PI. Variation in clinical case presentations certainly has been historically a core part of what GP life can be assumed to be about (Jones and Green, 2006). Although, interestingly, perhaps there has been an ongoing change on the discourse that Jones and Green (2006) allude to in the earlier part of the millennium. It is quite possible that with emerging changes in policy and practice that variation is being increasingly replaced by complexity, and this presents a differing nuance to the new (or older) GP (The Kings Fund, 2016). To clarify, with changing skill-mix utilising other members of the primary care team (including admin, nurses, pharmacists and paramedics) to see specific cohorts of patients, then GPs are being left with increasingly more complex patients. Thus, while capable of working at the 'top of their competencies' (Patterson et al., 2013), maintaining and sustaining this regularly does come with challenges of its own. Thus, might a trainee give consideration regarding if this is a career they might wish to choose? P5, p. 99 as a more newly qualified GP and aspiring GP trainer certainly seems to hint at such an issue.

This arena of working at the top of one's competencies, complexity and choice are not indigenous to general practice alone. Olsson et al. (2019) sought to examine this via the lens of power and discourse that is Bourdieu (2011) in their cohort (n=15) of physicians in training. Rich in narrative and drawing from several specialities (including GPs), their analysis proffered two main themes: an understanding of the medical profession and different specialities and positions in the medical field. What they suggest highlights many of the ideas that I have already espoused in earlier sections as well as this one, namely,

‘...When the participants describe their journeys to their chosen speciality, they talk about their paths to medicine per se...they consider their social background and upbringing important in relation to the medical profession...the contribution of family values regarding school...’ (Olsson et al., 2019, p. 448).

However, what the authors go on to highlight is that under the theme of positions within the medical field, those within general practice (amongst others) had to seek to defend their position of not ascribing to an 'organ-specific' or narrowed arena of illness types; often battling with the exalted position of surgery that continues to exist. Thus, whilst the focus from within this work was on power, from within my work on PI one notes how the concept of variety holds a meaning of interest for my participants regarding a broad-based approach, but also a need to 'defend' against others whom 'specialise'. P9, p. 100 reminds us of this very concept.

The status and identity of the generalist (as opposed to the specialist) is research that Muddiman et al. (2016a) has made commentary on. In their work, they draw on global discourse centred around definitions and roles of generalism with a focus on changing practices in one centre in the UK. Drawing on evidence from their longitudinal study (n=61) (Muddiman et al., 2016b) amongst others, they highlight how their generalist trainees surpass normative speciality restrictions, thus demonstrating more full ramifications for the generalist and interprofessional working - alongside changes to holistic, patient-centred care. While my participants do not articulate such nuances to this degree, what was evidently clear from my interactions with them is that in all of their contexts, having spent time in general medical or surgical settings, followed by possible specialised options, they sought to return to an area of medicine that offered them wholesome breadth and depth, i.e., General Practice, P6, p.100 argues this well.

Thus far, what we have seen influencing components that assist in the choices and thoughts a medical trainee undergoes in the journey to becoming a GP. What then, the crux perhaps of my research, is that which should ideally follow to allow for the GP to consider a movement towards education and being a GP trainer?

5.3 Being a GP trainer

In this final, predominant theme, six inter-linked sub-themes appeared as having connections towards enabling or inhibiting the PI formation of a GP trainer. As in the prior section, there was a typical nature of overlapping concepts. The six sections are composed of characteristics of the GP trainer (self), the GP practice, the roles of the GP trainer as clinician and teacher, a differing set of external influences, the relationship with the GP trainee and time.

Self

In the prior section, I have discussed the position of *self* with respect to my participant's interpretations of what that means to be a GP. Here, there is further level of detail when they have been asked to consider specifically what this might mean with respect to being a GP trainer. Participants articulated this in several ways, often remaining understated in their beliefs and values, however, some recognised that being a GP trainer carried with it something akin to a prestigious nature, e.g., P8 reflects on this despite ceasing to train, p. 97. Others spoke of it being enabling of PI via an enrichment or understanding of oneself and at the same time enrichment of the practice as further writing below describes, e.g., P5, a younger GP just embarking on the training process, p. 108.

Gibson et al. (2019) in their systematic review that sought to identify and amalgamate the skills and qualities of clinical educators in allied health professionals, including their impact on student education and patient care, yielded seven skills and qualities of interest. In particular, they noted that intrinsic and personal qualities of the educators were essential, with their table listing several values espoused by my own participants such as nurturing, trust or being empathetic and respectful. Although this review did not encompass GP trainers directly, it would be ameliorable to suggest that there is an overlapping consistency that appears to be true and transferable to my context and the espoused PI formation of my participants.

Interestingly, and one that I note within my own participants in the earlier recounts of being a doctor, e.g., P5, p. 90 and being a GP, e.g., P1, p. 99 is Gibson et al. (2019) whose commentary suggests one other important intrinsic quality, that of being sincere. Within my

participants I note that in a multitude of cases there seems to be an espoused value of being understated or even humble with respect to their PI as it emerged. Participants had often commented at one point in their stories that perhaps they ‘probably weren’t clever enough...’ or ‘...I wasn’t sort of super brilliant...’ yet here they all stand having attained both the status of a doctor, a GP and now a GP trainer, no mean feat in its own right.

Whilst trainer characteristics are an area that has been somewhat explored in the past (Garth et al., 2019; Spencer-Jones, 2010; Boendermaker et al., 2000) at the time of writing this concept of being understated in approach appears to have gone unnoticed. This might have salient value when it comes to encouraging and enabling GPs to consider and remain as GP trainers in that they might not recognise their true value and worth within an organisation. Thus, perhaps through recognitions such as the FRCGP above, or other such criteria, might there be leverage to acknowledge this more formally? Bearing in mind, as previously highlighted above that otherwise the RCGP appears relatively absent when it comes to the PI of the GP trainer and what comes to the forefront of their minds. Indeed, most recently, as the rest of the medical specialities seek to ‘catch up’ with the long-term policies already in place for general practice (GMC, 2018c), there now exists a GMC (2018d) ‘Recognition of Trainer’ status which is tied in with appraisal and revalidation processes such that the kudos of this position might be highlighted significantly more, perhaps via appraiser and other equivalent pathways (NES, 2020). However, these are issues that need highlighting or promoting, perhaps via more confident peers, local faculty or the RCGP directly, given the self-effacing nature of the GP trainers as commented on above.

In considering the evidence regarding GP trainer characteristics and states in more detail, Boendermaker et al. (2003, 2000) had already gone some way, as previously discussed, via their Delphi analysis, in attempting to define such characteristics. Although they use the latter term, their table of the 47 concepts was composed of teaching knowledge, teaching skills, teaching attitudes and personality traits, suggesting that there is more to this than meets the eye. I note that their Delphi synthesis was derived from their earlier, qualitative focus group analysis (Boendermaker et al., 2000) where they suggested that via their Netherlands GPs (10 focus groups, total number unquantified) there emerged 500 characteristics overall, which really brings into question how such data was robustly analysed, something left unmentioned in their work. This is obviously largely removed from the small number of characteristics that my participants make commentary on. However, I would argue that my

research, triangulated with participant checking would be much more robust and defensible in origins.

Although not directly spoken of, one wonders if some of the reticence noted in my participants is something that Sabel et al. (2014) refer to in their aptly named research, 'Medical Education Is the Ugly Duckling of the Medical World and Other Challenges to Medical Educators' Identity Construction: A Qualitative Study'. Acknowledging that the focus on the latter authors' work centres on a more generic cohort of early medical career educators per se (triangulated via senior medical educators) in the UK. What is noted amongst other findings is that there were some expressions of the lack of value (perceived or otherwise) that others might place on a medical educator's identity such that it could be possible to reduce an individual's self-esteem in this area. Whilst I would hope that this is of limited influence, as my writing will continue to show, there are opposing significant enablers which remediate such feelings. However, one should acknowledge that there are certain cohorts within the medical educator world that can feel this way. These feelings are importantly noted in the context of social identity (Tajfel, 1978) and not, like my research, from within SI. Therefore, social concepts and interactions that contribute toward the PI formation of the GP trainer are an important element to bear in mind as my commentary on the GP practice elaborates on below.

The GP practice

When I write of the GP practice in this context, I am defining this as the building, people and spaces that exists out with the persona of the GP trainer. Within my research the practice would appear to straddle the dimension of being both an enabler and barrier, with respect to an environment, towards the PI of the GP trainer, depending on context. The Kings Fund (2016) bravely attempts over a few short pages to succinctly capture some of the 'average' factors about what a GP practice might encompass, safe to say that this is a complex system of people, systems and environments that might be better dissected utilising a method such as Holden et al. (2013) suggest, but even then, likely underestimates significant factors at play. Thus, the GP practice is an intricate machine at the best of times, and what can be added to this is the GP training practice, a different cog altogether.

Earlier work by Waters and Wall (2008) has touched tentatively on this area albeit their focus at that period seems primarily on the division of labour by GP partners. The latter authors undertook a number of focus groups (n=23 participants) to discuss a series of issues centred on GP trainers and the local deanery, adopting a suitable analytical method underpinned by Activity Theory (Engeström, 1987). Amongst their recommendations included specific commentary regarding a need to support both the trainer and the practice. Indeed, my own participants certainly mention their GP partner's perceptions within the questioning that they underwent with me, e.g., P12, an experienced trainer in a practice with four other GP partners, p. 108, such that this would reinforce the literature above that which already exists on this matter. However, in addition to the clinical workload balance perceived by partners, there is also my participant's thoughts that are very much centred on logistical or structural elements e.g., rooms and space for a trainee to see patients given the ever extending multi-disciplinary team - but more importantly, recognition that the practice also gains a lot from having a GP practice training status.

To expand on this, I note via policy, that the training environment is recognised as being just as important as the GP trainer. Both GMC (2015, p. 8) policy,

‘...making sure that the environment and culture for education and training meets learners’ and educators’ needs, is safe, open, and provides a good standard of care and experience for patients...’

and subsequent national policy (NES, 2013) reinforce the same issues. Thus, the GP training practice environment is key. However, as much as ensuring that the GP practice meets the standards required to accommodate the GP trainer, is therefore acts also as an enabler with regards to providing sound argument and evidence of the benefits to the whole GP practice team, of the value in being a GP training environment. Indeed, this is something that appears to be new, in comparison to current literature from GP training, that is worth highlighting from my findings. Many of my participants wholly recognise that in addressing conditions and standards to meet GP practice training accreditation, is that the environment is also improved for the practice as a whole, e.g., P5, p. 108.

Externally to the UK, Michels et al. (2018) also allude to this issue. Although the authors only touch on how they make their recommendations via documentary analysis utilising an

iterative approach, what they highlight is that WONCA aligned with EURACT Educational and Performance Agenda again highlight clear and specific criteria that the GP training practice must hold. Absent, once more however, are the gains that can be made to the practice by holding such a position. Thus, we see, via my evidence, how the argument of the practice acting as an enabler towards the PI formation of the GP might hold a position yet undiscovered.

Discourse provided by Burford (2012) although drawn from social identity theory and focussed on the PI of the physician, can easily be transferred to this setting of the GP trainer and their practice also. In the latter research I am reminded that learning environments that affect identity formation are vast e.g., inpatient and outpatient facilities, classrooms, informal spaces of social interaction such that together can exist as motivators or barriers affecting individuals as they attempt to achieve an elected status. This could be argued to be true of the GP trainer just as much. And of the future? My participants could proffer no coherent theme that resulted in any predictive value, certainly none that could have anticipated the effects of a more recent viral outbreak (Haynes, 2020). However, if practice behaviours change to meet patient care needs, then it is likely that this might well influence the GP trainer's PI also, although how so, one cannot yet anticipate. However, perhaps one route, as indicated in my 'self' section above, is the utility of others to enable the GP trainer PI formation whilst there is engagement in GP training practice assessment or quality assurance processes.

Anticipation is perhaps what is being considered if we move from one side of the world to another. In the USA I note research via Carney et al. (2020) who sought to describe efforts to align primary care disciplines in residency community clinics in a bid to enhance primary care training for family physician trainees. In a mixed-method approach their qualitative themes noted that amongst the supportive elements of improving service requires the ability to take into consideration integrational and co-location of services. Both in terms of values-based activities, as well as physicality, in a bid to enhance and produce competent family physicians of the future. With pervading changes to GP interactions in the UK as seen via Health and Social Care partnerships of the future (Cook, 2015) then once more do we see the reinforcing component of the practice as it holds influence over the PI of its members within. Of course, each of these members within have a role to play, a point I now return to.

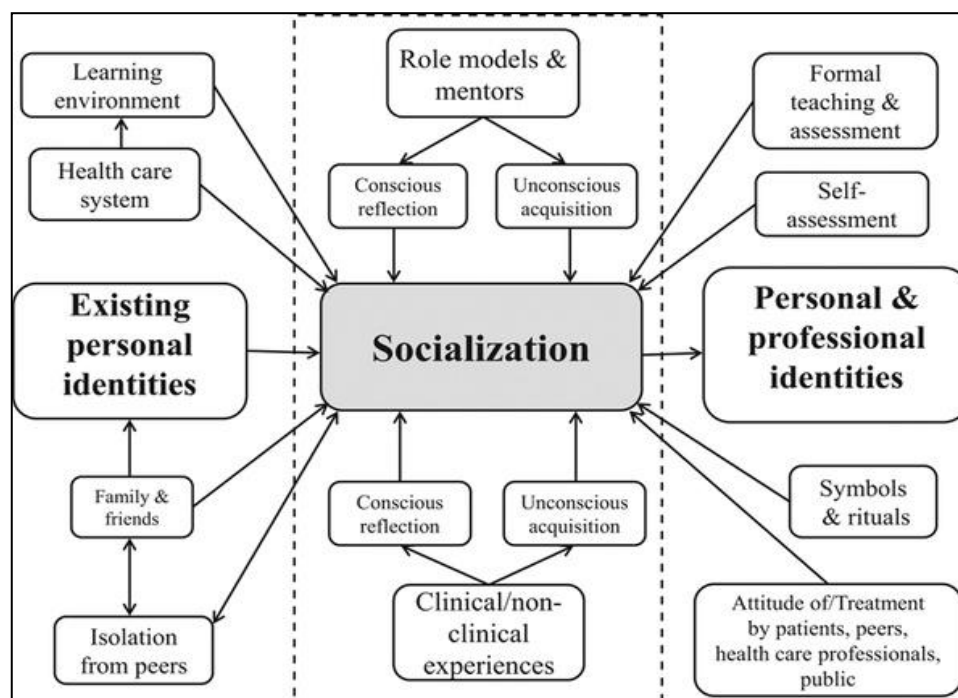
Within this section of ‘Becoming a GP trainer’ we see a new role emerge. Different from what I have discussed with respect to “Becoming a GP, not only do we see the existence of the role as pertaining to that of the aforementioned clinician, but now a new identity begins to flourish, the role of the teacher and the role modelling of that practice therein. With this, however, conflict is created, whilst the teacher role within my participants is very much an enabler, e.g., P4, now retired but still engaged with OOH, p. 115, the literature notes a differing story.

MacDougall and Drummond (2005) in their productions with experienced medical educators (non-GPs, n=10) write of how their participants have acquired educational knowledge and skills, role model and practice these skills, encourage and motivate other teachers, as well as being aware of educational constraints. In considering the GP medical educational literature I note that commentary regarding role modelling teaching skills specifically is very scarce and often isolated to an undergraduate context (Passi et al., 2010). In contrast, educational research is much more mindful of this with Beijaard et al. (2004) indicating this very early on in this century. Vloet and van Swet (2010) too have noted how the PI of teachers was formed through a dynamic process of continued interpretation and reinterpretation of teacher’s practices and biography. Thus, if one aligns with the concept of PI formation through SI descriptions of self, formed as a conduit through which prior social organisation structure reproduces themselves, one may begin to see how this supports the importance for the GP trainer to role model their self-defined identities, teacher included. P4, a 62-year-old, recently retired GP trainer with experience of approximately 15 years or more reminds us of this on p. 115.

On the other hand, the role of the doctor as a teacher has long since permeated the literature (Dandavino et al., 2007; Fitzpatrick and Heller, 1980; Goffin, 1942) with its Latin roots (Oxford English Dictionary, 2020) reminding us of it being ‘one whom teaches (*docēre*)’. Indeed P4, p. 115 has already retold us of this as well. Perhaps interesting too is that throughout this work and indeed with my participants, I have chosen to use the terminology ‘trainer’ being that which is recognised within medical education communities, as opposed to ‘teacher’ in what the literature reports, albeit I would purport, one and the same.

Returning to Cruess et al. (2015), whilst their guide for medical educators draws out the schematic representation of PI formation and socialization of medical students and residents, one can recognise within this how a medical educator, GP trainer included, could easily fit into such a world (see Figure 3). However, one needs to bear in mind, as the same authors highlight, that this PI formation is not a linear process. Tensions and conflicts can arise at differing or equivalent times, thus affecting an individual's reorientation towards their expected roles and performance within society. The conflict of the clinician versus the educator are certainly spoken about recurrently (Cantillon et al., 2016; Garth et al., 2019).

Figure 3: A schematic representation of the professional identity formation and socialization of medical students and residents from Cruess et al. (2015)



Indeed, my own participants echo this point clearly, e.g., P8, p. 112. One example of this narrative of conflict from the literature is exposed within work conducted by Garth et al. (2019) through qualitative research of their GP supervisors in Australia. In their context, the supervisor's (their equivalent of the GP trainer in the UK), thoughts and experiences were framed utilising Wenger (1998). Amongst the analysis, a theme emerges of this same concept of balancing the role of the clinician and the supervisor. Whilst the authors acknowledge that their sample was drawn from one area in Australia, they recommend a need in their setting for the supervisors to have adequate recognition and remuneration that reflects their work.

This is something I have already alluded to regarding the FRCGP or equivalent above as one example, with others within my writing yet to come.

Likewise, but by examining the literature via a scoping review, Cantillon et al. (2019, p. 1611) sought to ask a very similar question i.e.

‘...what was known about the relationship between the development of clinical teacher identity and the clinical workplace environments in which clinical teachers are situated?’

Their resultant themes suggest that identity was both individualistic in nature and could be composited as akin to ‘juggling’ (clinician vs. teacher), being mutually enhancing or being integrated. Cantillon et al.’s (2019) analysis also demonstrated a socially relational composite where identity could be contingent, negotiated (i.e., co-constructed between the individual and the workplace), organisationally informed or communicated. Thus, we see in my participants how there is perhaps a strong alignment between discussions suggestive of an individual ‘juggling’ elements juxtaposed with a social relationship, negotiated component, often reliant on the practice, as highlighted above. Ergo, we see in my research, aligning with the concepts espoused via SI, a world of the GP trainer as a teacher which is socially constructed and negotiated, often in alignment, but not always, with a clinical identity that runs in parallel, e.g., P1, p. 114.

Thus, for the GP trainer we have the challenges of enacting both the role as teacher, but also role modelling the clinician and the teacher. The latter concept is an area that has already been well recognised with the literature (Barber et al., 2019; Passi and Johnson, 2016). Most recently, Barber et al. (2019) sought to elicit such answers in work that resembles my research. In the latter authors case, their research question centred on barriers and enablers to GPs engaging with undergraduate education. Examining four UK medical schools, semi-structured interviews sought to unpick reasons from teachers new to teaching, experienced in their field or who had left teaching undergraduate medicine (echoes one can see of my participant recruitment strategies). In this research, themes were aligned with three communities of practice (Wenger, 1998): clinical practice, the medical school and teaching. Thus, once more we see this emulation within my participants of interactions connecting the

GP as clinician, trainer and the practice within which they work, something which P12, p. 108 had already spoken about.

Kluijtmans et al. (2017) offer a parallel world that also holds such similarities to the interactions described above. In Kluijtmans et al's (2017) context they highlight the PI of the clinician who is also a scientist, described as a brokering process between care and science. The latter authors study sought to investigate how recently trained nurse and physiotherapist scientists perceived their PI and experienced a crossing of boundaries between research and care following a masters research course. Analysis of 14 semi-structured interviews, albeit from one course in Utrecht highlighted several themes. Of importance to my research is the theme of participants expressing a dual identity of clinician / scientist as well as the theme of how the participants sought to connect science and care to improve health. Here, as in my research, one sees a pattern whereby the GP trainers endeavour to broker a dual identity of clinician and teacher, often with an aim to help their trainees help and improve future patient health care.

Of course, within the world of health care this dualism in identity is not something that is unique to the arena of the clinician and teacher. We see parallels exemplified via Spehar et al. (2015) who instead examined PI formation via the lens of clinicians who became managers. Being mindful that their context scrutinised 30 clinicians (16 nurse, 13 doctors, 1 other allied health professional) in managerial positions in one Norwegian hospital, the findings from their semi-structured interviews suggested doctors experienced difficulties in reconciling their role as a health professional with the role as manager, nurses transitioning much more quickly. Amongst the findings it is notable that many of their participants spoke of being a clinician first, the manager role coming second, thus we see challenges for some in this cohort as they seek to integrate or accommodate a caring role with one that differs. In my research the participants appear to work against the backdrop of prioritising clinician over teacher, or in some cases one (usually the teacher), is sacrificed for the other e.g., P8, p. 112.

Helping patients, caring, is the essence of role modelling as a clinician that Passi and Johnson (2016) speak to in their study. Here, the authors sought to investigate the impacts of positive doctor role modelling as well as develop an understanding of the processes by which role modelling brought about these changes. In a robustly constructed process (n=52 medical students, n=25 consultants) their findings highlight how the role modelling manner is a

complex composite of at least six exposure items (clinical expertise, relationship with patients, colleagues, students, clinician personality and being inspirational) that distils into an evolutionary phase for the students to reflect and process in their own way. Thus, as my participants have spoken directly about, my GP trainers sought to enable their trainees via a PI informing component that strives to mentor by example, e.g., P1, p.114. Overall, therefore, we see a dualism for the GP trainer, predominantly positively orientated, to consider in this area of PI formation, to enact and role model, both the clinician and the teacher. Sustaining this can have some costs, and is influenced by other external factors, these I describe further below.

External Influences

The inter-related complexities that are contributed from the five dimensions of external influences affecting the professional identity of the GP trainer are challenging to untangle when aligning with the literature. In isolation, one often can find commentary, academic or otherwise (Hayward et al., 2015; Spencer-Jones, 2010; Waters and Wall, 2007) but they are often as not, linked to clinical context rather than educational settings per se. As a reminder these dimensions include: SPESC, the deanery, out-of-hours (OOH) GP arrangements, political influences and the GP trainer's group and thus all sit within the research sub-question that asked of the effects of external drivers or environments.

Nearly all of the participants (n=15) spoke of the value of the current GP trainer's training course in Scotland i.e., Prospective Educational Supervisors Course (SPESC) (NES, 2018c), e.g., P2, as one whom has recently completed this course, p. 103. Notably, the one participant who didn't was the same GP who was at the contemplative phase of becoming a GP trainer and thus unlikely to be wholly orientated yet to this educational terminology. SPESC (2018) itself has been in various iterations since 2001 (Shackles et al., 2007) before a nationwide approach was adopted in 2014 as outlined earlier. Prior to that we have seen variable and differing variations in GP trainer training from region to region and nation to nation. This continues despite prior policy recommendations about the need for a harmonised approach, albeit Scotland has sought to do this as a country (Lyon-Maris and Scallan, 2013).

Spencer-Jones (2010, 1997) has written intermittently on this area, drawing on some of the available evidence convenient at the time. His remarks suggest that there was inherent value

in the course albeit further evaluation of this would have been useful. Steinert et al. (2006) in their systematic review of faculty development allude to findings that would seem to match both my data and what Spencer-Jones (2010) suggest. The latter being positive changes in attitudes following a course such as SPESC. Furthermore, participants note an increased knowledge in educational principles with gains in teaching skills in such a course as well as positive changes in teaching behaviours, consistently given in feedback by students or trainees, e.g., P5, p. 103.

Student and trainee feedback is only one strand of a large web of literature with respect to ‘training the trainers’ programmes, and as such has multiple threads of argument that will not all wholly centre on GP trainers. Thus, I have elected to acknowledge but be wary of incorporating specifics from this area within my work as SPESC forms only one small part of the PI formation jigsaw. Looking externally from the UK however, we can see how Michels et al. (2018) might once again have bearing on this context. Already critiqued above, what is worthy of noting here is that there is commentary that all teachers are appropriately accredited, something that SPESC does in alignment with the GMC (2018c) recommendations on the same process. This is reinforced by my participants’ reflections on their positive personal gains e.g., P14, p. 111. However, aside from SPESC, there are other external factors at force in my research.

The deanery, out-of-hours (OOH) GP arrangements and political influences whilst standing out as clear sub-themes from within my study have overlapping roots of influence and power. GPs, as independent practitioners undergo intervals of negotiation and renegotiation with government over the types of medical services that they will provide to the community. These reiterations of medical services contracts lend to historical and current changes in the configuration and deliveries of health care systems via the practice and their staff. One element amongst these were transitions in 2004 (Parliament (Scotland)) freeing the GP from the need to provide personally 24 hours a day, 365 days a week, care to their patients. Thus, became established a separate out-of-hours (OOH) service that would deliver this work. With this change in contractual arrangements, however, came about changes in interactions and clinical supervision for the GP trainee as established by my participant’s narrative, P9, despite being long-time retired, p. 105, was very clear on this concept.

Hayward et al. (2015) are one of the few to date to construct research that addresses such change. In their setting they sought to explore OOH training in England for a cohort of their GP trainees. Adopting a questionnaire approach, 221 doctors completed elements of their tool. What was notable in their discussion was that in comparison to research conducted in an older cohort (pre-2004 changes) trainees post 2004 overall felt less confident in dealing with OOH work albeit more than three-quarters indicated they would still work within OOH after their CCT. Fast forward nearly 10 years later and research by the Scottish Government (2013), bearing in mind that this differs contextually from the English cohort above, suggests that policy changes within OOH continue to have effects. The 2013 survey gathered new information on GPs working in OOH and noted that GPs aged under 35 accounted for just under 24% of the overall number of individuals who contributed to the service over that year, their combined hours accounting for 13% of the total hours input in that same period. In contrast, GPs aged over 55 whom accounted for 14% of the overall headcount but 19% of the total hours input over the survey year. Whilst the report makes no direct mention of OOH GP trainer or trainee educational training per se, what we see reflected in this data, locally and anecdotally (STV News, 2015) is a reduction in OOH commitment by GPs, perhaps worsened by geographic constraints. Either way, the changes seen within policy have sought to create a disruption in the educational relationships that existed in older OOH training methods. With respect to my research, some trainers saw the release from OOH commitments as a positive thing, whilst others recognised that something was lost, e.g., P9, now retired, p. 105.

Here is an area where we have seen the deanery provide change that might be viewed as supportive. In Scotland, the deanery (NHS Education for Scotland, 2018a) now holds and oversees human resource arrangements with regards to the GP trainee, OOH included. Thus, as the responsible employee, the deanery has sought to create arrangements, not only to ensure that the GP trainee is still required to complete an element of OOH training, but that they have the opportunity and processes in place to ensure that this happens, feedback included. Thus, although not all GP trainers might elect to accompany or construct an arrangement so that they attend OOH with their trainee (an area we see later with respect to trainer / trainee relationship), at least there still exists clinically OOH opportunities for the trainees; an element however, a GP who wishes to be a GP trainer must keep in mind as this still forms a component of their PI, chosen or otherwise. I will return to the deanery again, this time however, via the final element of an external influence, that which is the GP trainer's group.

I have already described to some degree that in the PI formation of the GP trainer there has been significant recognition from my research of the value for trainers in the SPESC course, a deanery led activity. However, what support is encountered thereafter for the GP trainer? Locally, with provision facilitated via the deanery, there exists programme leads and contacts who work with and on behalf of NES (2018b). Amongst the supportive options on offer, as well as formative assessment advice and assistance, locally and nationally programme leads facilitate GP trainer's groups. These are intermittent opportunities whereby the GP trainers can arrange to meet, formally and informally to discuss ongoing issues relevant to GP training and their trainees. Waters and Wall (2007) have already highlighted literature with respect to GP trainer groups is sparse, this remains the case. What the previous authors did note was that in their research, 80% of their cohort had utilised trainer workshops (regarding ongoing development) on a regular basis. This does not surprise me given my own insider experiences with my interviewees, what does is that there appears to be no significant directive or driver suggestive of the utility in the trainer's groups as a method to help and encourage GPs to become GP trainers. Indeed, my own professional experiences, whilst relatively positive, have noted variable positive and troublesome behaviours elicited from GP trainer groups depending on time, person and context. Whilst national policy alludes to such mechanisms,

‘...Organisations must support educators to liaise with each other to make sure they have a consistent approach to education and training, both locally and across specialties and professions...’ (GMC 2015, p. 30)

The GP trainers in my study have been variable in their thoughts and feelings about the usefulness of the trainer's group and deanery support therein, e.g., P1, p.104 and their unsettling experience. Reaching further than the UK however, educationally, Starr et al. (2003) note this in their work with teachers in the USA who claimed that they wished to provide impact to people. In the latter author's setting, they interviewed 35 community preceptors in five focus groups to test the relationship between teacher identity and positive outcomes by seeking to understand what factors contributed to a strong sense of teacher identity in physicians. Again, amongst the themes that emerged, many of which I have already recounted above, was a particular commentary on belonging to a group of teachers, thus suggestive that there can be utility in such gatherings.

This is certainly one area that might seem ripe for future exploration in order to tease out in differing detail regarding just what it is that happens within these groups that may affect the GP trainers and those seeking to become one. One clear value of the trainer's group, however, is as a forum to discuss issues encountered with respect to the GP trainer / trainee relationship, something I now highlight in more detail

Trainee relationship

The importance for the GP trainer that within their PI exists the concept of how they nurture and build upon the relationship they have with their GP trainee is invaluable. All participants have discussed this to greater or lesser degrees, sometimes encompassed by the positive experiences they have encountered, sometimes via negative situations. Thus, in considering the research question, the GP trainee is an essential, predominant enabler, towards the PI formation of the GP trainer.

Beaulieu et al. (2008) seem to suggest that due to a generational gap rather than being a nurturing effect, there is a potential barrier between the 'trainer' and the doctor wishing to become a family physician. However, the evidence within medical educational literature is relatively bereft of such findings. Educationally, Hamman et al. (2010) do discuss the concept of teachers being caring within their 'possible selves theory'. The latter authors sought to investigate dimensions of possible selves of new teachers to construct a generalisable picture of the same cohort. Two hundred and twenty-one USA teachers completed a data collection protocol which allowed for subsequent categorisations and coding (quantitatively). Their results speak of correlations between categories that included classroom management, instruction, interpersonal school relations and professionalism. In the latter two of these we can see some reflections of my participants and their qualitative commentary that could be positioned with respect to relationships between the GP trainer and their trainee, juxtaposed with professionalism that arises from the clinician / teacher that I have spoken of earlier. In one example I note how P3, despite being contemplative in their role towards GP training, p. 1113, highlights how the outcomes of the trainee with respect to RCGP exams reflect on the persona of the trainer themselves, albeit the RCGP appears otherwise bereft in contributing towards trainer PI.

One can see this more clearly articulated outlined in rapport via the qualitative research as exemplified by Boudreau et al. (2014). In that work, there is a return to examine the relationship using the longitudinal process that I have outlined previously. On this occasion, Boudreau et al. (2014) sought to understand the apprenticeship learning process and its PI formation as seen through the experiences of participants on a physician apprentice course. Adopting a case study design, groups of teachers and students had several data sets collected in a mixed-methods approach. Amongst the findings espoused was significant commentary on the formation of meaningful relationships, i.e., teacher-student bonds that developed were described as very strong. Strong enough as such that the article portrayed the teachers in questions as taking on the role of ‘loco parentis’ (Boudreau et al., 2014, p. 1042) at times. Thus, like my participants who spoke of ‘...it’s like having your own child...’ (P7, p. 111), we can see the same issues replicated within my findings. Whilst Boudreau et al. (2014) speak of the apprentice in relation to a very unique type of newer emerging health care profession i.e., the physician apprentice (or associate), apprenticeship is strongly linked with the teacher / student relationship within the literature as whole, indeed also with policy.

Remaining with policy I note that the GMC (2013b, p. 36) who directly comments on the need for an ‘apprenticeship-based relationship’ set out clear recommendations on how apprenticeship might be arranged between trainers and doctors in training. Importantly, the same policy suggests that not all doctors should be trainers, nor all workplaces, thus ever suggestive of my argument that certain PI formational elements of the trainer appear to influence the context over what might be an ideal training environment for the trainee. The same policy also highlights with this section, commentary on the importance of personal supervision (ideally by a named supervisor) in order to enhance opportunities for the trainee, to build confidence, and allow trainers to ascertain competency of the trainee, thus competency is deemed important.

Although competency is viewed as important, this was not a strong theme of discussion that emerged from my findings. Within policy, yes, it is often discussed, and to some extent hinted at in the context of the MRCGP as above, but for the GP trainer it is not an overt theme of influence regarding PI formation. Perhaps this therefore aligns with Jarvis-Selinger et al. (2012) whose title ‘Competency Is Not Enough: Integrating Identity Formation into the Medical Education Discourse’ hints at the same issue. In their commentary, the latter authors

sought to provide a conceptual analysis of issues and related language, in order to understand the relationship between the development of competency and PI formation during medical training. Utilising selected evidence sources the authors speak, once more, of the professional who is generated from both the individual, and the social context, suggesting that competency-based training and assessment might tend to minimise what is a dynamic and evolutionary process. What I interpret from this, is the point, as perhaps my findings and their absence suggest, that competency forms only one small part of what a trainer is considering, especially with regards to the relationship they have with their trainee.

However, when all is said and done, there is no doubt that competency can and does play an important part with respect to the trainer / trainee relationship. Perhaps more so with regards to the trainee who appears to have difficulties in attaining the required proficiencies needed to allow the completion of their CCT. This is certainly reflective within the findings suggested by my participants. Many of them highlighted that via personal experiences, of those reported to them (often a common thread of GP trainer group discussion) the ‘doctor in difficulty’ might pose a barrier to those who undertake the role of the GP trainer, e.g., P3, p. 113.

Assisting the GP trainer with the trainee in difficulty is not solely left to the trainer alone, the deanery are there to help with underpinning training and policy (NHS Education for Scotland, 2011) and supporting frameworks do exist. Barnhoorn et al. (2018) provides one such, clearly constructed framework for remediating unprofessional behaviours and for enhancing professionalism competencies and PI. However, whilst recent in the literature one must bear in mind that Barnhoorn et al. (2018) is derived from commentary on best evidence, rather than constructed from underpinning methodology per se, and directed towards the medical student in difficulty, albeit many of the areas outlined are transferable to a postgraduate setting. This said, what the frameworks offer are an approach to the doctor in difficulty, by the medical educator in order to help the trainee find out who they are and whom they wish to become, over an extended period of time i.e., their PI.

PI for the student and explanations for poor standards of care is also the focus of the topic explored by Traynor and Buus (2016) in their research with nursing students. These authors were interested in examining areas of healthcare workplaces that caused nursing students early in their careers to have anxiety around PI formation. Their research questions focussed

on determining what would characterise the development of PI of student nurses as they talked about experiences of clinical work in the UK NHS. Forty-nine students in six focus groups were facilitated. Thematic analysis suggested that the predominant areas of discussion included concepts such as caring that was tangible and came naturally, yet there were ‘good’ and ‘bad’ nurses. Strategies to avoid becoming the latter were articulated. Interestingly, the authors’ discussion deemed their findings inconclusive in terms of offering specific methods of remediation as suggested by the nursing students themselves, concluding that the idealism of newcomers might give way to disillusionment, with some nurses learning to temper this with practical concerns. Perhaps within this discourse then is a hint to what some of my participants bore in mind. In a GP trainer’s case, more often than not there are overwhelming positive outcomes and sequela associated with the ‘good’ GP trainee and their relationships. When difficulties do arise, if not too often nor too severe such that they would ‘put someone off’ completely, then they can be tempered by pragmatic solutions and frameworks to redress the nature of the problem.

If this is the students’ viewpoint of the situation, what say then of the teachers? Shanahan et al. (2019) might have something to proffer regarding such an issue. The latter authors’ research sought, via phenomenological enquiry, to explore the lived experience of 12 medical schoolteachers from two sites in Southern Australia, whom had dealings with an episode of serious student conflict. In a robust approach, their analysis suggested that the major themes to consider were that clinicians reflected on the student behaviour, the emotional impact it had on the clinicians and their responses to such a conflict. P5, p. 113 offers some insights into how he felt he would often wish to address such issues. Notably, assessment processes were often deemed to be part of the conflict, if not a ‘tipping point,’ with many of their participants admitting that in the future they would alter student assessment or reconsider their involvement in student teaching. Thus, like my participants, we can see how the ‘challenging’ trainee doctor might evoke some change in feelings with respect to how one views a GP trainer PI. Managing such behaviours, not only evoke emotional residue, but are also likely to require more periods of involvement to address, record and review, all of which takes more time, the last theme explored in this writing.

Time

It had been unsurprising from the outset, signposted within my initial study and reaffirmed via the main research, that time remains a significant barrier with regards to the PI of the GP trainer. Supporting evidence from with the literature reaffirms this position also (Prins et al., 2019; Waters and Wall, 2008; Pitts et al., 2005)

I have already highlighted earlier within the context of ‘the practice,’ research established by Waters and Wall (2008) in their GP trainer analysis. One further salient theme amongst their findings was their participant’s commentary on time as a barrier, in this context towards continuing professional development. Their participants talked of being conscious of the need to strike a balance between time spent on developing themselves in their teaching role versus other professional activities i.e., those required of the clinician. My participants spoke less about professional development per se and more about the actual time needed in supporting, monitoring and supervising their GP trainees be that on in work-based settings in close proximity, or when the trainees will be on other clinical placements in hospital, e.g., P8, p. 112, who was notably struggling to retain their PI of the trainer.

Striking similarities regarding time as a barrier and workplace-based assessments in general practice can be reflected in work by Prins et al. (2019). The latter research, set within Danish GP speciality training, sought to explore factors influencing the implementation of a new workplace-based assessment programme, something already long term in place with the UK GP environment. Prins et al. (2019) developed a questionnaire which they invited trainees and supervisors (the equivalent of UK GP trainers) to complete (n=128). Analysis derived from Likert scale differences and thematic free-text analysis suggested that one of the primary barriers to implementing such tools was time (along with lack or being prepared or lack of it being a priority). Thus, whilst quantitatively driven we see an echoing of some of the perceptions of my own participants albeit not espoused via work-based place assessment directly. P6, as a trainer who continues to assist GP trainees who have exam challenges, p. 112, was very empathetic with his commentary that there is a time resource on the delivery of support that is required.

Interestingly, from within my own findings, I had expected the assessment processes or the tools (i.e., the RCGP portfolio) to emerge as a predominant theme. This was not the case. When participants spoke of time this was often in the context of how time to perform the role of the GP trainer fitted in and around ‘the practice,’ the ‘role of the doctor’ and was informed by the relationship with the GP trainee. Thus, if we return to examine the findings proffered earlier by Gibson et al. (2019) in their systemic review this would seem to fit quite neatly with what I have uncovered. The latter offers within the skills suggested of a clinical educator one that needs to ‘understand expectations’ (akin to the trainer / trainee relationship and the requirements of the MRCGP amongst others), as well as consider the clinical educator in their ‘professional role’ i.e., that of the GP. Thus, time is a barrier but only when taken into consideration of the plethora of other themes and components that I have already alluded to in this writing.

Goldie et al. (2015) also provide one final element that reinforces my findings regarding time as a barrier toward GP trainer PI formation. Noting Gibson et al. (2019) latterly, what Goldie et al. (2015) had suggested even before this, whilst an apprenticeship model was still felt to be relevant in clinical settings, it has to be balanced against the need for systematic teaching. Noting that the latter was conducted in a medical school / Scottish NHS clinical setting, what we see via the analysis of these clinical educational supervisors (n=10) was that structural or institutional change had an influence on teaching capacity which was woven within time and staff availability to supervise. P1, p. 111 was quite vocal in his comments that time was a clear requirement that should be built into such processes.

Unsurprisingly, if we look at teaching overall, we see that time remains a predominant barrier. Avidov-Ungar and Forkosh-Baruch (2018) in their teaching research in Israel (n=27) highlight that specific time must be set aside for teachers if they were to construct and implement teaching associated with new technologies. Likewise, Yin Ong et al. (2019) in her work with occupation therapists and physiotherapists (n=39) also noted in her qualitative analysis that an individual’s mediation of clinical and educational roles results in competing priorities and time impediments. Thus, time is, and perhaps always will remain, a significant barrier that must be planned for and taken into considerations with respect to the PI of the GP trainer, one that is significantly represented within my interview data.

In summary, I have explained what the barriers and enablers are, as I have researched, that facilitate a General Practitioner *becoming* a GP trainer. In doing so we see that GP trainers have the potential to transition across three stages over a longitudinal process: ‘Becoming a Doctor,’ ‘Becoming a GP’ and ‘Becoming a GP trainer.’ The GP trainer role suggests tendencies for clinicians to be understated in reports of their achievements and abilities. The GP trainer dually enacts and role models that of clinician and teacher; time acts as a significant barrier regarding both. The current SPESC, or previous iterations, is a significant enabler. GP trainer associations with OOH services have changed over time. GP trainer / trainee relationships are essential enablers to a continued GP trainer PI. These findings have implications for future policy, practice and research, bearing in mind that there are limitations to this work. I will conclude with these in the final section.

Chapter 6: Conclusions

This study addressed the primary research question regarding, ‘What are the barriers and enablers that facilitate a General Practitioner *becoming* a GP trainer?’ In doing so, it has positioned itself to address that which is centred on the PI formation of the GP trainer by applying a construct that is framed via symbolic interactionism. An approach that has not been done, as far as I know, regarding GP trainers and the work they perform. Thus, this case study has produced findings, some of which, add new theoretical and practical knowledge to an area of the literature less explored by others. Whilst I have applied the framework of SI, I have also retained the guidance of Cruess et al. (2014) to interrogate and enlighten the physician identity that is the GP trainer bearing in mind their suggestions that,

‘...a physician’s identity is a representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized, resulting in an individual thinking, acting, and feeling like a physician...’ (Cruess et al., 2014, p. 1447)

As such, my findings speak to the research question by indicating that a GP might arrive at the role of being a GP trainer through experiences and events born of transitions across three predominant identities: ‘Becoming a Doctor, ‘Becoming a GP’ and finally, ‘Becoming a GP Trainer.’ Hindrance at any of these stages will result in the arrest or cessation of the outcome of the PI formation of the GP trainer. I am of the mind that the route travelled towards being a GP trainer is thus potentially precarious and requires recurring support and assistance to ensure current and future generations of GP trainers continue this professional identity formation.

My findings bring together core barriers and enablers, acknowledging that these themes and sub-themes can contribute from both extremities of being obstacles and facilitators in the PI formation of the GP trainer. In doing so, they coalesce under the uniqueness that belongs to the field of symbolic interactionism. Each of these ascribed elements act in unison to influence the PI of the GP trainer, thus there exists the risk that one or more might act as a ‘tipping point’ to influence the GP trainer in continuing or relinquishing their role. This is certainly more powerful with the current tensions of the NHS (Haynes, 2020).

In ‘Becoming a Doctor’ the analysis drawn from participant questioning and policy documentation found three sub-elements contributed towards this theme: friends and family,

internal drivers and secondary education. These elements have been acknowledged in the literature in the past (van den Broek et al., 2020; Vries-Erich et al., 2016; Aschbacher et al., 2010), my findings in this area add further weight towards this same evidence, via my distinctive type-2 case study (Yin, 2014); my interview data in particular. Wass et al. (2017) have recently set the stage for several tasks to be undertaken that help amplify these findings concerning enabling a person to consider a career as a doctor. Issues that have been reinforced more recently by Gillies et al. (2020). My research, I might debate, can be said to align and build on these current recommendations and suggestions. With respect to the GP trainer, at this point in a student's career, during the entry period to medical school and the early undergraduate years, merely highlighting the language and existence of the identity of the GP trainer, as I have indicated on p. 122 would be considered an improvement on what is usually provided, from my experience and that of my interviewees. Later medical school years would allow for the opportunity to present fuller discussions about the nature of the route into GP training programmes and the specific practises which that entails.

In 'Becoming a GP' seven critical sub-themes exist in the narratives of my participants and triangulating policy. Inextricably linked in nature they consist of a set: external influences, making one's mind up, the MRCGP, the GP's role and its variety centred within work/life balance, and GP as self. Policy (Gillies, 2019), longitudinal processes (Bartlett et al., 2019) and newly emerging directions (Pope and Dubras, 2020) continue to set the direction of medical students' training and in doing so, provide opportunities for undergraduates to interact with and see what it is a GP does more clearly. Especially when the GP enacts this out as a positive role model.

My findings differ from the literature to date in that the MRCGP can no longer be considered a barrier, when it comes to the future GP trainer, given that policy has changed such that it is a requirement for anyone who wishes to become a GP to now hold this. At this point in a doctor's career, I would suggest that there are now clear opportunities for the GP trainer to be clearly outlined in presence within teaching and training. The same trainers also eloquently role model how to manage variations in clinical work that exist in the medical arena. In exemplifying these deeds, they allow for the opportunity to demonstrate how the GP and GP trainer are comfortable in dealing with uncertainty and how one addresses work / life balance. In doing this, one should be aware that the novice doctor is often still in the process of

deciding about future career trajectories. Thus, one seeks to enable them, in a positively supportive manner, ‘make their mind up’ as my findings indicate.

In ‘Becoming a GP Trainer’ six inter-linked issues (see p. 83) serve to act as the barriers and enablers towards the core centre of this PI formation. Reinforced by my participant checking via synthesised, analysed data (Birt et al., 2016), these are organised via the self of the GP trainer, the GP trainer’s roles as a clinician and teacher, the relationships with the GP practice, and with the GP trainee, encompassed by a set of external influences and bounded by the constraints of time. The literature already concedes to acknowledging the importance in the GP trainee relationship (Shanahan et al., 2019) and the connections between the GP trainer and their GP practice (Waters and Wall, 2008). However, I would seek to argue that my research has uncovered new and specific findings within a number of these sub-themes, e.g., educational enrichment and being inconspicuous.

Unreported to date in the literature, and derived of past experiences, with regards to the self-identity of the GP trainer there is a tendency for them to be understated in the nature of their achievements and abilities. This likely professional ‘invisibility’ would appear to be an important element to take into consideration, when it comes to bearing in mind how to highlight and celebrate the successes that evolve from becoming a GP trainer. As such, this is something one needs to be mindful and encourage or even reward. My research aligns with the literature (Garth et al., 2019) regarding the challenges for the GP educator who juggles the role of the clinician and the teacher. What I add to this which is novel is that the GP trainer is also endeavouring to role model both these professional identities at times, not just enact them. With respect to external influences, my findings signal that it would be timely to re-explore the value in the current SPESC course as this is spoken of rarely, despite its positive value to the GP trainer. Likewise, the GP trainer and their relationship with OOH has now changed significantly, my research reveals a need to examine this area in greater detail.

My type-2 case study (Yin, 2014) suggests that the current GP trainer PI has been derived from predominantly historical arrangements and conditions. This dynamic needs to be re-explored in the modern climate more fully in future inquiries. Ultimately, my research reinforces a constant message that time to perform this important role is precious to the GP trainer and needs to be formally recognised and protected. While policy does highlight this already (GMC2015), at the time of writing, I remain sceptical that this is always enacted or

supported, especially by the ever-pressed practice. In terms of future professional activities, I make further recommendations below; however it is first important to acknowledge the limitations in this research.

6.1 Trustworthiness and limitations of the study

I have already alluded to a series of checks and balances that I have attempted to keep in place to ensure that the research question being addressed was done so in a robust and rigorous manner. Korstjens and Moser (2017) cite well-known criteria as defined by Lincoln et al. (2017) regarding the trustworthiness of the research by being identified by its credibility, transferability, dependability and confirmability; these are additionally encompassed by my researcher reflexivity which I have addressed earlier.

In attending to the credibility of my research, several elements have been considered. I have attempted to conduct a prolonged and persistent engagement via multiple, substantive interviews with the participants involved (Korstjens and Moser, 2017). I acknowledge that one might argue a one-time interview with these participants may not provide a richness offered by recurring, in-depth interviews and follow-up with the same individual over time. I would argue that the quality of data obtained and represented in chapters 4 and 5 does, nevertheless, do justice to the analytic approach I have adopted. However, I have already counterposed with respect to the necessary constraints that I envisaged this would create for the participants, and indeed time as a barrier was a predominant finding of this research. Ethically and personally, I would always make a case that a researcher needs to feel at ease with the demands being made on those who helpfully participate in the research.

This said, through the processes of corroboration (Varpio et al., 2017), noting that there are a variety of types as suggested by Tellis (1997), i.e., data source, investigator, theory and methodological, I have sought to enhance the authenticity and credibility processes further. More specifically, I have utilised a complementary documentary analysis that has been described in order to add another dimension to these processes. Due to the individual nature of this study and the requirements of the doctorate, it was not possible to enhance the credibility of this research by utilising more than one investigator as a data collection triangulation process. However, once the themes were constructed, I applied a synthesised

method of member checking (Varpio et al., 2017; Birt et al., 2016) to confirm or refute my findings. Ultimately, however, in constructing the themes, I am of the view of that as proposed by Morse (2015, p. 1216) that ‘...the researcher's background in theory and research methods must (lead them to) outrank the participant as a judge of the analysis...’

I have already given considerable time and weight to both the literature and the underpinning theory with respect to constructing the design and practice of this research. Given that the existing body of work, more than often, draws on the nature of the quantitative investigator, I have been loath to consider this specific type of design being utilised in my research, thus arguably reduce its originality. Indeed, I would still dispute that such approaches risk losing the essence and fine detail of what it is that *being* a GP trainer concerns. This said, it might pose future benefits following this wholly qualitative approach in order to demonstrate in a differing way any findings uncovered. In contrast, however, I have given significant credence to the application of alternative theories in my approach. Particularly those concerning the thematising of my study via Goffman (1974, 1971) as he does hold particular appeal given the nature of his work and associations with the presentation of self. However, given the roots of my study, while SI in nature and their alignment with an ethnomethodological approach, I thus elect to allow my findings to stand by themselves, drawing upon, but not necessarily driven by this theory itself.

In standing by themselves, I would hope that any reader of my research will deem the inherent value of the findings and conclusions and can judge for themselves the transferability of my research into their similar contexts or as a gestalt for the design of future studies. In doing so, I return to my earlier justifications that this research aimed to construct a thick and rich case study of the findings that have direct implications for future GP trainer recruitment, practice and policy formation.

In conclusion, the barriers and enablers towards the PI formation of the GP trainer emanate from first ‘Becoming a Doctor’, then ‘Becoming a GP’ and finally ‘Becoming a GP trainer’. With respect to the latter there exists a multi-dimensional set of themes and sub-themes that create a precarious equipoise that might seek to allow a GP trainer to retain or reject their trainer role. The external influences of the deanery, politics, the GP trainer’s group, OOH services and SPESC form one unit of influence; only SPESC acts as an enabler alone, the remainder traversing both dimensions of being positive and negative influencers. Acting

wholly as enablers, the GP trainer's positions of being a teacher and a role model are central. So too is the trainer / trainee relationship. The trainee must be present to allow a continued GP trainer PI to exist and nurture their novice, time spent as a trainer enhances this situation whilst doctors with difficulties might impede progression.

Positively underpinning all of the above, GP trainer characteristics of being attracted to education allows for PI formation enrichment, all the while retaining an understated approach. The GP trainer's own practice can significantly help bolster this educational role as long as there exists fairness in work perceptions from within the practice partners and staff. Time remains a significant barrier to GP trainer PI formation. I have made a number of suggested recommendations that might seek to redress this situation whilst staking my claims towards my personal contributions towards the literature. However, prior to this I note some of my personal reflections as a researcher and how this has affected my own PI with respect to being a doctoral candidate.

6.2 Reflections on personal identity formation as a doctoral researcher

Drawing on a reflective framework as aligned with Gibbs (1998) I note some salient points that have evoked and changed my professional identity as a researcher. These have also been similar to the processes that Cruess et al. (2015) report with regards to PI formation in medicine as a whole (Figure 3).

My starting position regarding existing personal identities has been as a clinician and more specifically a GP who was also a GP trainer. Indeed, in pursuit of an academic career my GP trainer identity was 'given up' due to a change in jobs from GP partner to GP lecturer, ultimately resulting in a move both geographically, as well as contractually, from NHS to university domains. This also necessitated leaving a GP partnership and a GP training practice to work within an academic setting, albeit I have retained clinical ties to preserve my medical practice. These identities have existed prior to fully embracing a doctoral programme but I carry with these, feelings of loss (at leaving my GP partners, the practice and patients) as well as enthusiasm (at moving into a university academic department). Family and friends too have been important influences with regards to supporting my career changes and trajectory; however, peers who have completed doctoral research, yet have been GPs, or even

more so, GP trainers, are few and far between, thus there has been some sense of isolation in this journey.

Unsurprisingly then, I have sought out equivalent role models and educational experiences, consciously and unconsciously in order to assist my PI formation as a doctoral researcher. Part of this process involving completing personally, and then supervising others, with respect to master's level research. In electing to apply and join the educational doctoral programme at the Open University I made a personal decision to challenge myself to attain higher levels of contributions towards research and the scientific community that exists, albeit mindful that this has been a demanding and enduring journey.

Along this path I have had the opportunity to explore and question my current thinking regarding what it means to achieve 'doctoralness' from the early days of being introduced to Boote and Beile (2005) in year one seminars, to the confidence I feel I have grown in my ability to construct a full doctoral thesis and successfully defend its stance within a viva setting. McNaughton (2016) reminds me that higher education roles are constantly shifting in response to contextual change; this is something I have regularly encountered as I have balanced the progressive elements of this research process along with clinical work and other academic duties. Especially concerning the covid pandemic that has affected the latter end of my journey. Learning to adapt to these shifts in life is something I feel I have learned from and hope to continue to apply in future research and teaching work. In particular, my flexible researcher approach, albeit still mindful of trying to ascertain academic rigor to my work.

In considering my research and participant encounters in more detail I have noted a mixture of emotions as I have progressed through the challenges of recruitment and interview processes. My own excitement and enthusiasm with this research have been tempered by the practical limitations associated with trying to encourage and arrange timings to see my GP colleagues. Some of my peers and counterparts have reciprocated such enthusiasm within their interview dialogues, whilst others have been more tempered or distracted in their conversations by events born of parallel clinical or personal issues. Keeping participants on track, yet allowing them the space to articulate their feelings in alignment with my research question has not been easy at times. I have noted I have had to draw on my skill set as a clinician within a consultation environment to create signposting in the conversations to keep

my participants direction on par with my research interview schedule. A skill I shall retain for future research projects.

Regarding documentary analysis this has been a somewhat more arduous affair. It has been surprising to note that policy and practice regarding GP trainers was somewhat dearth in nature and lacking in anything that was not subsumed by commentary that tends to rest on either a process born of the GP practice (building) or embedded within multiple other specialty data reports (Appendix 12). These documents, ultimately revealing little in nature with regards to the PI formation of the GP trainer. None the less, this absence in data in some ways has helped spur me along the track of completing my analysis and constructing findings that I can relate back to my research aims.

As a teacher I feel that I have endeavored to transfer the criticality of my doctoral thesis and experiences into the world of my current research students that I work with and supervise. As Morse (2015) articulates, I now regard myself more strongly associated with elements of the social sciences of which my research is aligned. In particular concepts such as that previously espoused in my writings via the theories of symbolic interactionism (SSSI, 2019) and important within research, elements including rich and thick descriptions, awareness of researcher bias, member checking and the essence of triangulation amongst others (Morse, 2015).

As this part of my doctoral journey draws to an end, I am mindful of the need to translate my writings and research into products that add useful contributions to the research and wider audiences that I have highlighted at the beginning of this section. Creating work that is digestible to what one might view as both an ‘academic’ yet also a ‘wider GP audience’ will likely continue to prove challenging in itself. As my earlier reflections have indicated, not all or many of my GP colleagues would view themselves of having an ‘academic’ interest. Therefore, translations of this work into findings that will still provoke interest or serve to generate new directions of travel for the PI formation of the GP trainer are something that I have yet to construct. The most salient components of these regarding future policy, practice and research are summarised below.

6.3 Future policy, practice and research

With regards to future policy and practice I would suggest that the following might aid in directing the current discussions towards newer trajectories:

- The role of the GP trainer as a teacher and medical educator needs to be highlighted, beginning from early undergraduate days and building on the descriptions and routes towards this professional identity, into postgraduate life.
- Aside from adhering to policy and protocol requirements, the deanery, locally or nationally, needs to consider emphasising and enhancing the status of the GP trainer. Particular attention to the possibility that these are individuals who might be understated in nature, despite their daily achievements, yet positive enablers and teacher / role modelers needs direct attention.
- The RCGP should reconsider their position with respect to GP trainers and how they might better support them in the role that they undertake given that currently, MRCGP aside, there is little mention of the college. A clear directive from RCGP regarding support and development of the professional identity of the GP trainer is required. The relationship with an FRCGP status in particular needs to be addressed.
- Time remains a significant barrier for the GP trainer, processes that protect and minimise this are likely to enhance the positive contributions of being a teacher and thus maintaining that role. In particular, a realistic workload.

In terms of future research, it would be viable that a number of routes could be explored that might further promote the professional identity of the GP trainer and their associated connections. My suggestions include:

- A focus specifically on the value and utility of the Scottish Prospective Educational Supervisors Course (SPESC) given the changes that have evolved over GP trainer training and status in the last decade. One might give particular emphasis to the PI of the GP trainer and those that facilitate such programmes that have emerged out of iterations, evaluations and revisions of this course (assuming these processes have occurred) over time. One example being what have been the lived experiences of facilitators or participants on the SPESC course.

- A highlight on the specific utility and value of the GP trainer's group in its contribution towards the PI of the GP. What is it that happens to make some GP trainer groups proactive and effective whilst others might be somewhat construed as dysfunctional and lethargic in nature? This same exploration might also lend itself to the bereft of commentary that was noted with respect to RCGP and its contributions.
- Attention in particular to the nature of the PI of the GP and the GP trainer in the context of newer OOH arrangements which has become grounded as an important NHS service in its own right. One approach to this may be to ask what are the barriers and enablers towards a GP undertaking regular OOH sessions post MRCGP qualification?

Whilst these future research recommendations can be borne in mind, and notwithstanding the contribution of my thesis, it is helpful also to be mindful of the limitations of my work. Thus, I will end this writing with a reminder of issues that should be considered.

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Appendix 1: Literature search criteria

Inclusion and Exclusion Criteria for GP Trainer (Teacher)

	Inclusion Criteria	Exclusion Criteria
Subject: GP Trainer (Teacher)	<p>Term ‘GP Trainer or Teacher in the article title</p> <p>‘GP Trainer or Teacher in the subject area</p>	
Design	<p>Original Research</p> <p>Reviews</p> <p>Systematic Reviews</p> <p>Editorials</p> <p>Commentaries</p> <p>Letters to the Editor</p>	Teaching Guides
Language	English	Non-English
Publication Date	Articles published 1 Jan 2000 to 31 June 2017	Articles published up to 31 Dec 1999
Source	Any source available through access via The Open University	

Inclusion and Exclusion Criteria for Professional Identity and Medicine

	Inclusion Criteria	Exclusion Criteria
Subject: Professional Identity	Term 'Professional Identity & Medicine' in the article title 'Professional Identity & Medicine' in the subject area	
Design	Original Research Reviews Systematic Reviews Editorials Commentaries Letters to the Editor	Teaching Guides
Language	English	Non-English
Publication Date	Articles published 1 Jan 2000 to 31 June 2017	Articles published up to 31 Dec 1999
Journal	Any source available through access via The Open University	

Inclusion and Exclusion Criteria for Professional Identity and Teacher

	Inclusion Criteria	Exclusion Criteria
Subject: Professional Identity	Term 'Professional Identity & Teacher' in the article title 'Professional Identity & Teacher' in the subject area	
Design	Original Research Reviews Systematic Reviews Editorials Commentaries Letters to the Editor	Teaching Guides
Language	English	Non-English
Publication Date	Articles published 1 Jan 2000 to 31 June 2017	Articles published up to 31 Dec 1999
Journal	Any source available through access via The Open University	

Appendix 2: Professional identity and medicine search summary

Electronic Search Engine	Date	Search Terms	Hits (Retrieved)	Selected for Review
OU library search:	17/07/2017	Title: PI & medicine	79(34)	34
		Subject: PI & medicine	78 (2)	As above
British Education Index	17/07/2017	Title: PI & medicine	0	-
		Subject: PI & medicine	14	4
Conference Proceedings Citations Index - Both	18/07/2017	Title: PI & medicine	0	-
		Conference: PI & medicine	0	-
Educational Research Abstracts	18/07/2017	Only one search option exists	1422	Defer to EdD running list
Educational Resources Information Centre	/18/07/2017	Title: PI & medicine	0	-
		Subject: PI & medicine	3	Duplicates
PubMed	19/07/2017	Title: PI & medicine	12	Duplicates of others
		Subject: PI & medicine	315	2
Scopus	21/07/2017	Title: PI & medicine	13	3
		Subject: PI & medicine	509	14

Appendix 3: Publicity e-mail and leaflet



Dear Colleague

Research into '*Becoming a GP Trainer – Exploring the Barriers and Enablers*'

I am writing to ask if you would be prepared to help me with an important study about your experiences of becoming a GP trainer. I am conducting this research as part of an Educational Doctorate with The Open University.

The aim of the research is to explore the professional identity formation of the GP trainer by becoming involved in an interview and discussions about your experiences of this. In doing so it is hoped that the findings from this work might lend themselves to recommendations and a framework that allows the potential for both local and national recruitment and retention of GP trainers; something invaluable in the current socio-economic arena.

Your views and experiences would be invaluable in this process. The attached leaflet has detailed information about the research and what would be involved in taking part. I ask that you read it before making any decision about participating.

Thank you very much indeed for your help. If you are interested in being a participant in the study then please contact me as below. In the meantime, if you have any queries at all about the study, please feel free to get in touch so I can answer your questions.

Yours sincerely

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Appendix 4: Pre-interview data sheet

Name:

Gender:

Date of Birth:

Ethnicity:

Type of secondary school attended e.g. state, comprehensive, private etc:

University attended:

Year of university graduation:

Year commenced work as fully qualified GP:

Do you hold the MRCGP?

When / by what route do you obtain the MRCGP e.g. nMRCGP, via MAP, etc?

Do you hold the FRCGP?

Do you hold any further medical education qualifications?

Year you started as a GP trainer?

Have you attended any of the following?

- | | |
|--|----------|
| • SPESC course | Yes / No |
| • New educational supervisor workshop | Yes / No |
| • Experienced educational supervisors workshop | Yes / No |

Did you start training at an established training practice?

How many sessions, if any, do you currently work in your training practice?

Appendix 5: Semi-structured interview guide

Opening Questions		Provisional rationale / RQ link
	You've told me that you studied at school. What influences if any did this have on your choices to be a doctor? Where there any other influences?	Relax the participant
	What were the biggest influences on you and your learning and development as a doctor at medical school?	
	And so following graduation at University tell me what jobs did you do then?	
	And so when did you decide to become a GP?	
	What do you think were biggest influences on you and your development as a GP?	
Transition Questions		
	Tell me about your current role is and how long you have been doing that?	
	What does the term 'identity' mean to you, if anything? When or where have you heard this term?	Exploring understanding of identity
	So thinking about identities? When you hear the term 'GP trainer' what does being a GP trainer mean to you?	Exploring understanding of identity
Key Questions		
	How important is your role as a GP trainer? Does it enhance or detract from your role as a GP?	Understanding of role Salience of role
	How has your identity as a trainer evolved over time?	Growth and development
	What would help strengthen your identity as a trainer?	Enablers
	What would weaken this identity as a trainer?	Barriers
	Has GP training changed during your time as a trainer? <ul style="list-style-type: none"> Probes for MRCGP, FRCGP, further Med Ed if not already discussed, MAP Probes for established training practice 	Future directions
	What do you think a GP trainer should be like in the future? <ul style="list-style-type: none"> Probes for sessional commitment 	Future directions

Final Questions		
	Of all the points discussed related to the role of a GP trainer which seems the most important to you?	
	Is there anything else you feel we should talk about in relation to this issue which we haven't?	
Closure		
	<p>We will have to draw things to a close</p> <p>Explain what will happen next – clarify for member checking</p> <p>Thank participants</p>	

Appendix 6: Participant information leaflet



Dr Kevin McConville (Research Student)
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Technology (CREET)
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Further information (Q&A) about:

Becoming a GP Trainer – Exploring the Barriers and Enablers

What is the aim of this research?

The purpose of this study is to understand why GPs become a GP trainer (educational supervisors) including any experiences, attitudes or behaviours that may help or impede this process. The study will focus particularly on answering the research question: What are the barriers and enablers that facilitate a General Practitioner becoming a GP trainer?

Who is conducting the research and who is it for?

Dr Kevin McConville is carrying out this research as part of his doctoral thesis with The Open University. It is hoped that the findings from this work might lend themselves to recommendations and a framework that allows the potential for both local and national recruitment and retention of GP trainers; something invaluable in the current socio-economic arena.

Why am I being invited to participate in this research?

You have been identified as a past, current or future GP trainer. For this reason, we would like to invite you to participate in this research.

If I take part in this research, what will be involved?

I will be conducting a one-to-one interview sometime between December 2017 to December 2018. The interview would aim to take no longer than 60 minutes maximally and would be conducted at your home, workplace or another location if you prefer, at a date and time that is convenient to you. To ensure your safety, I will carry photographic identification.

What will the interview be like?

In your setting of choice, you will be asked for some specific information relevant to your background. I will then ask you a series of questions whilst providing you with the time and space to reflect and respond. Some of the initial questions may be followed up with further queries at that time to clarify or expand your thoughts in more depth. You can decline to answer questions should you choose as well as stopping the interview at any time. The interview will be audio-recorded and then transcribed at a further date. You will be offered an opportunity to comment on the summarised findings at a later date if you wish.

What will we be talking about?

You will be asked initially about your experiences of doing medicine, followed by your experiences of becoming a GP. Primarily there will then be a focus on why you have considered choosing to become a GP trainer and what this may have entailed for you.



Is it confidential?

Your participation will be treated in **strict confidence** in accordance with the Data Protection Act. No personal information will be passed to anyone outside the research team – essentially myself and my two supervisors. There will be a written report of the findings from this study, which might include quotations that can be used in publications or conference proceedings however no individual will be identifiable in published results of the research. I am however bounded by the General Medical Council's "Duties of a Good Doctor" in light of findings that might be seen as posing a risk to the participant or others.

What happens now?

Over the next few weeks, I may contact you by e-mail to follow up on your initial expression of interest. I aim to interview GP trainers with varying degrees of experience but cannot guarantee that I will see everyone who volunteers to take part, although I would hope to include most.

What if I have other questions?

If you have any other questions about the study I would be very happy to answer them. Please contact:

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Contact details for an alternative contact – my main supervisor - if you have any concerns about the way the research project is being conducted:

Dr Lynda Foulde-Hughes
lafulder-hughes@open.ac.uk

Appendix 7: Reflexive journal extracts

Monday 10th July 2017

Design made during the week to stop OOH to allow for complete Monday night focus on this work and it does feel somewhat a relief (is there something about OOH and the GP trainer also?). There was sense of being overwhelmed about balancing things, aside from the 'hangover' tiredness on Tuesdays. Finances we will have to be watched but hopefully this will be ok for the future. For now I really need to focus on reading ++ and also some writing. I have aligned time lined within 2018 to ensure I get good writing time. Right now the literature rework must come first to inform the interview schedule and this will allow ethics to progress. All of this by Oct!...Have also created additional mind maps to allow for methodological issues as I need to be able to articulate well my approach - and why other issues have been ruled out!

Monday 17th July 2017

You have completed Jenkins -Social Identity book over the weekend. What does it tell you? It certainly goes back to the key influencing authors you are encountering often i.e. Mead, Foucault, Tajfel so this you must be happy with, but also there seems to be a need over linkage again with reflective practice too. SI comes up time and time again which is a helpful dimension in one place...

Tuesday 15th August 2017

Leading on from last night's work and post reflections / you are currently doing RPP revisions so in reflective mood. The 6 minute write to get some writing done. Your 'where now' doc suggests you really are at the place to review the literature. Last night you spent some time exploring issues tied in with interpretation vs constructivism vs social constructionism, all of which sits within endnote. You are feeling clearer about this and even more clear about narrative and why it won't work as it is 'backwards' - at least for the last article read in that it starts with the stories then looks to see what they show rather than a semi structured interview and framework. Last night was somewhat of a liminus area - Is it coming together and you are becoming better accustomed to the writers - the pressure is on

however to create the semi structured interview guide and sort out ethics as part of the PRO2 process within Oct.

5th March 2018

XX was the 1st ppt done in (name place) and so I was a nervous about doing it and 'getting it right' as he much as he was about 'providing it. There were some pressure given he was going off to NZ for a sabbatical for 7 months but I knew from his trainer experiences he would be useful to have. I think my feelings were often mixed; some matched the empathy that I had with him and shared experiences of being a GP trainer and could understand very clearly his frustrations or emotions - at others the e.g. the coughing fit or when the question didn't seem to make much sense to him I was more in my 'own state' as the researcher and worried about getting him to say the 'right things'. On reflection actually having down more interviews whilst I keep an eye on the interview structure I have learnt to relax and allow tippet to keep stalling and as some of my ongoing reading has suggested listens, listen, listen. I think the transition questions needs to have a clearer lead in and I am not certain that the 'important question point;' are absolute. I will continue to monitor the effect of these questions in what has been so far the shortest of the interviews but still very useful.

May 2018

Reflections from interview ppt 3

I note that although I go where the ppt goes I'm sometime then lead 'astray'. I had asked specifically for influences in medical school that made him think about being a GP but he skipped over this and went direct to FY stuff instead and I never really followed up on this because of the 'logical progression' of where the conversations was going then. A reminder that this is a younger GP who is just getting going in some ways. The split site is also an important element both split site in terms of his current practice but also in terms of in his GP training days the dynamics associated with (practice name) and the fact its 2 practices in the one building...and do they really get on...?

In this practice on review of the tapes and I guess I was aware of it - aside from direct interruptions with the telephone (ethics) there was lots more background noise and movement

from ongoing practice activities which didn't wholly distract things but I was aware of them being there. I guess in my own rights as a GP I am also always mindful of the time. 60 mins max seems a long time in my GP head but I would wish for longer as the researcher. The same in reviewing the tapes would I have wanted more....is this a self-imposed pressure of time..?

Double dilemma / researcher issues of knowing the GPs and the practice a bit more intently and treading the line there. I certainly felt better at 'not going there' at times when it was likely they were looking for direction to answer some of the questions.

February 2019

A thought from RCGP faculty board - **9.6 College Consultation on Future of General Practice** - Discussion to take place regarding the summary document attached and then everyone can fill in the survey – 3 boxes to type in narrative and we can do a collective response if we wish - Reminder for EdD that this feeds into this...not within the data though...ie RCGP as a deficit commentary?

November 2019

Some thoughts as they enter my head from reading Carter & Fuller...this element of the unseen - you are a GP trainer when it is not obvious to others i.e. why is it e.g. ethnography would not have worked - not only from the elements of the pragmatics but because there are times when you are being a GP trainer not seen by others e.g. e mail communications / portfolio work etc..

Appendix 8: Thematic analytical framework

Thematic Analysis of Data adapted from Braun and Clarke (2012)

	Phases	Description of Analysis Process
1	Familiarizing myself with the data	a) Narrative preparation i.e. audio listening and transcribing b) (Re)-reading the data and noting down initial ideas
2	Generating initial codes	c) Coding interesting features of the data in a systematic fashion across the entire data set d) Collating data relevant to each code
3	Searching for themes	e) Collating codes into potential themes f) Gathering all data relevant to each potential theme
4	Reviewing the themes	g) Checking if the themes work in relation to the coded extracts h) Checking if themes work in relation to the entire data set i) Reviewing data to search for additional themes j) Generating a thematic 'map' of the analysis
5	Defining and naming themes	k) Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells l) Generating clear definitions and names for each theme
6	Producing the report	m) Selection of vivid, compelling extract examples n) Final analysis of extracted examples o) Relating the analysis back to the research question, objectives and previous literature reviewed

Appendix 9: Word cloud illustration of initial codes



Appendix 10: Summary of the initial codes from the data

Code Name	Sources	References
GP trainer identity = this role	1	1
GP trainer future - adjusting hospital posts	1	1
Medical career influences - technology	1	3
Medical career influences - tv	1	1
GP trainer enabler - remuneration	1	1
GP career - influences of day release	1	1
GP trainer enabler - route via undergrad	1	1
GP trainer future - don't know	1	1
House jobs - see one do one teach one	1	1
GP trainer barrier - alternate teaching opportunities	1	2
GP identity = vocation NOT a job	1	3
GP trainer future - curriculum changes	1	1

Day release examiner contact	1	1
GP trainer - EESW	1	1
GP trainee future - five years	1	1
GP trainer enabler - good trainee	1	1
GP trainer future - extended training	1	2
GP identity = do the right thing	1	1
GP trainer future - technology	1	1
GP trainee future - clearer training structure	1	1
GP trainer identity - the not so good trainer	1	2
GP trainer future – inter-practice work	1	1
GP identity = NOT a position	1	1
Medical career influences - own health	2	2
GP trainer = characteristics	2	2
GP identity = honesty	2	2
GP identity = value and integrity	2	2

GP trainer training - life timing	2	2
GP trainer identity = flip in & out from clinical	2	3
GP trainer future - begins at undergrad point	2	2
GP trainer identity- the tools used	2	2
Medical career influences - academic pathways	2	4
GP trainer future - role of others	2	2
GP trainer barrier - admin	2	2
GP identity = generalist	2	2
GP trainer enabler - nGMSv2	2	3
GP trainer barrier - split site	2	2
GP career - Remote & Rural	2	3
GP identity = service provision	2	3
Medical career influences - Medical school open day	2	2
Medical career - independence	2	5

GP trainer identity - political influences	3	5
GP trainer barrier - portfolio	3	5
GP trainer identity = self-belief	3	5
Training practice teamwork	3	4
GP trainer identity = role or not the role	3	4
Reflection	3	5
School progression	3	3
GP trainer identity = part of the community	3	4
GP identity = trust	3	3
GP trainer as identified by their trainer	3	3
GP trainer identity = having a trainee	3	7
GP trainer barrier - apprentice_assessment conflict	3	3
GP trainer future - continuity	3	6
GP trainer = attraction	3	4

GP trainer future - expert generalist	4	6
GP identity = who you are	4	4
GP trainer barrier - the application process	4	7
GP trainer barrier - faculty support	4	9
Not being a GP trainer = easier	4	5
GP career - lack of conviction	4	4
GP identity = enhances learning	4	4
GP identity = culture & characteristics	5	7
Finances	5	12
GP career - avoidance surgery exams	5	7
GP trainer enabler - faculty	5	6
Medical career - scientist vs humanistic	5	6
GP trainer identity = encouraging the attitude	5	8
School type	5	5
GP identity = something special	5	7

GP career - variety	6	13
GP trainer identity - OOH	6	11
GP trainer identity = prestige	6	8
Teacher in circle	6	7
GP trainer identity = as a challenger	6	7
GP trainer identity = knowing about knowing	6	10
GP trainer - strong teaching practice tradition	6	13
GP trainer - assists with prospective planning	6	9
GP trainer identity = understanding you as a GP	6	9
Medical career influences - friends	6	7
GP trainer training - time on the clock	7	13
GP trainer identity = apprentice_expert	7	12
GP trainer barrier - lack of trainee contact	7	14
GP trainer identity = enrichment	7	12

GP trainer identity = role modelling	7	12
Medical career influences - intrinsic	7	11
GP identity = role	8	12
Inspiring role model	8	14
MRCGP	9	15
GP trainer barrier - perceptions of work	9	17
GP career - early teaching contact	9	16
GP trainer training - the trainer's group	9	18
GP career - making mind up	10	14
GP career - political influences	10	20
GP trainer identity = teaching	10	21
GP career - work_life balance	11	16
GP trainer barrier - Dr in difficulty (Dr)	11	17
Medical career influences - secondary education	11	15

GP trainer identity = good for the practice	11	17
GP trainer - SPESC influences	11	23
GP (trainer) - being understated	11	23
GP trainer barrier - time	12	30
GP trainer barrier or enabler - practice	13	29
Medical career influences - family	14	32
GP career - environment influences	14	53
GP trainer identity = nurturing the trainee	14	33

Appendix 11: NVivo example of coding processes

The screenshot displays the NVivo software interface, which is used for managing and analyzing qualitative data. The interface is divided into several main sections:

- Left Panel (Navigation):** Contains a tree view of the project structure. It includes 'SOURCES' (Internals, Externals, Memos), 'NODES' (Phase 1 - Familiarise with the data, Phase 2 - Generate Initial Codes, Phase 3 - Search for themes, Phase 4 - Reviewing Themes, Phase 5 - Defining and Naming Themes, Phase 6 - Produce the report), 'CLASSIFICATIONS' (Source Classifications, Case Classifications), 'COLLECTIONS' (Sets, Memo Links, Annotations), 'QUERIES' (Queries, Results), and 'MAPS'.
- Central Panel (Codebook):** A table listing the codes created during the analysis. The columns are 'Name', 'Sources', 'References', and 'Created On'. The codes are organized into a hierarchical structure, with some codes being expanded to show sub-codes.

Name	Sources	References	Created On
Becoming a Dr	0	0	28 Apr 20
Medical career influences - intrinsic	6	8	1 May 20
Medical career influences - own health	2	2	1 May 20
Medical career influences - scientist vs humanistic	5	6	1 May 20
Medical career influences - family	14	32	1 May 20
Medical career influences - friends	5	6	1 May 20
Medical career influences - secondary education	14	26	1 May 20
Becoming a GP	0	0	28 Apr 20
GP identity = honesty	2	2	1 May 20
GP identity = who you are	3	3	1 May 20
GP identity = trust	4	5	1 May 20
GP identity = culture & characteristics	5	7	1 May 20
GP identity = something special	5	7	1 May 20
GP career - variety	6	13	1 May 20
GP identity = role	8	12	1 May 20
MRCGP	9	15	1 May 20
GP career - making mind up	10	14	1 May 20
GP career - environment influences	11	42	1 May 20
GP career - work_life balance	11	16	1 May 20
Becoming a GP trainer	0	0	28 Apr 20
GP trainer enabler - route via undergrad	1	1	1 May 20
GP trainer barrier - admin	2	2	1 May 20
GP trainer barrier - split site	2	2	1 May 20
GP trainer enabler - nGMSv2	2	3	1 May 20
GP trainer identity = flip in & out from clinical	2	3	1 May 20
GP trainer identity- the tools used	2	2	1 May 20
GP trainer training - life timing	2	2	1 May 20
GP trainer = characteristics	3	3	1 May 20
GP trainer barrier - apprentice_assessment conflict	3	3	1 May 20
GP trainer barrier - portfolio	3	5	1 May 20
GP trainer identity = having a trainee	3	7	1 May 20
GP trainer identity = part of the community	3	4	1 May 20
GP trainer identity = self belief	3	5	1 May 20
Training practice teamwork	3	4	1 May 20
GP trainer = attraction	4	5	1 May 20
GP trainer barrier - faculty support	4	9	1 May 20
GP trainer barrier - the application process	4	7	1 May 20
- Right Panel (Report):** Displays the title page of the research report. It includes the PRUComm logo, the title 'General practitioner recruitment and retention: An evidence synthesis', the subtitle 'Final Report', the date 'February 2016', and the names of the authors: Professor Stephen Peckham, Dr Catherine Marchand, and Anna Peckham. A disclaimer at the bottom states: 'This research is funded by the Department of Health. The views expressed are those of the researchers and not necessarily those of the Department of Health.'

Appendix 12: Summary of documentary sources

Document Type	Title	Author / Source
Policy	A Framework for the Professional Development of Postgraduate Medical Supervisors Guidance for deaneries, commissioners and providers of postgraduate medical education	Academy of Medical Educators
Policy	Fit for the Future - A vision for general practice	RCGP
Policy	From the Frontline - The changing landscape of Scottish general practice	RCGP Scotland
Policy	General practitioner recruitment and retention: An evidence synthesis - Final Report February 2016	Policy Research Unit in Commissioning and the Healthcare System
Policy	Promoting excellence: standards for medical education and training	GMC
Policy	Quality Management of GP Specialty Training in Scotland Terms of Reference and Standard Operating Procedures for Educational Supervisor and Training Practice Approvals	Regional Policy Management Groups
Policy	RCGP Scotland Scottish Blueprint for general practice	RCGP
Policy	Recognising and approving trainers: the implementation plan	GMC
Policy	Shape of Training. Securing the future of excellent patient care	Final report of the independent review Led by Professor David Greenaway
Policy	SPESC generic guide	SPESC
Policy	The RCGP Curriculum 1 Introduction and User Guide	RCGP
Policy	The RCGP Curriculum: Core Curriculum Statement 1.00: Being a General Practitioner	RCGP
Policy	The RCGP Curriculum: Professional & Clinical Modules 2.01–3.21 Curriculum Modules	RCGP
Policy	The Trainee Doctor	GMC
Policy	Teaching general practice - Guiding principles for undergraduate general practice curricula in UK medical schools	Society for Academic Primary Care
Legislation	GMC web clippings on GP Trainer Legislation / Medical Act 1983	GMC
Legislation	Medical Act 1983	UK Government
Legislation	NHS Vocational Training Act 1973	UK Government
Information updates	General Practice Forward View – April 2016	NHS England
Information updates	Medical Directorate Education Research and Innovation Group Annual Report 2019	NES
Information updates	National Training Survey Scotland 2016	GMC

Information updates	National Training Survey Scotland 2016 – Key Findings	GMC
Information updates	National Training Survey Scotland 2013	GMC
Information updates	National Training Survey 2013: summary report for Scotland	GMC
Information updates	National Training survey 2014 Key findings	GMC
Information updates	National Training survey Key findings from the pilot survey of trainers	GMC
Information updates	Postgraduate Medical Education Annual Report 2013	NES
Information updates	Postgraduate Medical Education Annual Report 2014	NES
Information updates	Postgraduate Medical Education Annual Report 2015	NES
Information updates	Postgraduate Medical Education Annual Report 2016	NES
Information updates	Postgraduate Medical Education Annual Report 2017	NES
Information updates	Postgraduate Medical Education Annual Report 2018	NES
Information updates	Quality Annual Report - The Scottish Deanery - 2017	NES
Information updates	Quality Annual Report - The Scottish Deanery - 2018	NES
Information updates	Scotland Deanery News 2017	NES
Information updates	Scotland Deanery News 2018	NES
Information updates	Scotland Deanery News Spring 2018	NES
Information updates	Scotland Deanery News Summer 2018	NES
Information updates	Scotland Deanery News Winter 2018	NES
Information updates	Scotland Deanery News Winter 2019	NES
Information updates	Local GP Trainers Annual Conference Update	NES
Information updates	The National Training Survey 2015 Infographic Overview	GMC
Information updates	Training environments 2017 - Key findings from the national training surveys	GMC
Information updates	Training Environments 2018 - Key Findings	GMC
Information updates	Training Environments 2018 - 4 country breakdowns	GMC
Website Information	About us – Scotland Deanery	NES
Website Information	GP trainer and training practice accreditation	NES

Website Information	Key Dates & Events	NES
Website Information	Quality Management - Trainer Information – Scottish Deanery	NES
Website Information	Quality Management - Trainer and Trainee Surveys	NES
Website Information	Recruitment - Scottish Medical training	NES
Website Information	Scotland Deanery - NHS Education for Scotland	NES
Website Information	Scottish Trainer Framework - Scotland Deanery	NES
Website Information	SPESC - Scotland Deanery	NES
Website Information	SPESC - Orientation	NES
Website Information	SPESC - Application Form	NES
Website Information	Trainer Information - Scotland Deanery	NES
Website Information	Trainee Information - Scotland Deanery	NES
Website Information	www.scotlanddeanery.nhs.scot~quality~approving	NES
Website Information	www.scotlanddeanery.nhs.scot~quality~enhanced-monitoring	NES
Website Information	www.scotlanddeanery.nhs.scot~quality~framework	NES
Website Information	www.scotlanddeanery.nhs.scot~quality~governance	NES
Website Information	www.scotlanddeanery.nhs.scot~quality~improving	NES
Website Information	www.scotlanddeanery.nhs.scot~quality~monitoring	NES
Website Information	www.scotlanddeanery.nhs.scot~quality~quality-workstream	NES
Website Information	Your Development ~ Scotland Deanery	NES
Miscellaneous	BMA GP Contract 2016 - Principles	BMA / Scottish Government
Miscellaneous	BMA GP Contract - Joint Letter to GPs	BMA / Scottish Government
Miscellaneous	By choice not by chance web final	NHS Education for Health
Miscellaneous	Gender in the NHS 2018	NHS Employers
Miscellaneous	GMC-National-Review---Scotland-national-report-2018	GMC
Miscellaneous	NHS Education for Scotland Performance Support Unit	NES
Miscellaneous	Primary Care Workforce Survey 2017	NHS National Services Scotland
Miscellaneous	RCGP assessment blueprint June_2012	RCGP
Miscellaneous	RCGP Scotland manifesto 2015	RCGP
Miscellaneous	Quality Outcomes Frameworks guidance documents 2016 - 17	BMS / NHS

Miscellaneous	SAPC letter EURACT Dec 2018	Society for Academic Primary Care
Miscellaneous	Scotland Deanery ES training practice eligibility criteria	NES
Miscellaneous	Training practice accreditation application	NES

Glossary

Certificate of Completion of Training	Award provided to a medical trainee in order to allow then to exit as a consultant / GP
Clinical Supervisor	Someone whom oversees the clinical work of a specified doctor in training throughout a placement, provides constructive feedback during that placement, leads on providing a review of the practice of the doctor in training throughout the placement that will contribute to the educational supervisor's report on whether they should progress to the next stage of their training
Educational Supervisor	Someone whom is responsible for the overall supervision and management of the educational progress of a doctor in training during a placement or series of placements, helps the doctor in training to plan their training and achieve agreed learning outcomes, is responsible for the educational agreement, brings together all relevant evidence to form a summative judgement at the end of the placement or series of placements. GP trainers are educational supervisors to their assign GP trainees
Fellow of the Royal College of General Practitioners	Award granted to a GP from RCGP in recognition of a significant contribution to medicine, and general practice in particular with respect to: health and welfare of the community, science or practice of medicine and aims of RCGP, or any organisation which benefits general practice
Foundation Year	A doctor in their first (FY1) or second (FY2) year of medicine after graduation. (See also Junior House Officer /Senior House Officer)
General Practitioner	One whom ascribes to GP/ family medicine as an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care

GP Specialist Trainee	A doctor enrolled in a GP training programme, commonly of three years in length i.e. GPST1, 2 or 3
Junior House Officer	Historically used to describe a doctor in their first year of medical training after qualification (see Foundation Year)
Out of Hours	The time period out with the normal functioning hours of practice of a GP / GP surgery, normal being Monday – Friday, 0800 - 1800
Professional Identity	A physician's identity as a representation of self, achieved in stages over time during which the characteristics, values, and norms of the medical profession are internalized, resulting in an individual thinking, acting, and feeling like a physician. (Cruess et al., 2014, p. 1447)
Senior House Officer	Historically used to describe a doctor in their second or subsequent year of medical training after qualification (see Foundation Year) who had yet to enter a training programme.
Scottish Prospective Educational Supervisors Course	The Scottish Prospective Educational Supervisors Course is a 12-month course delivered by NES and a requirement for a GP trainer to complete prior to being allocated a GP trainee in Scotland.